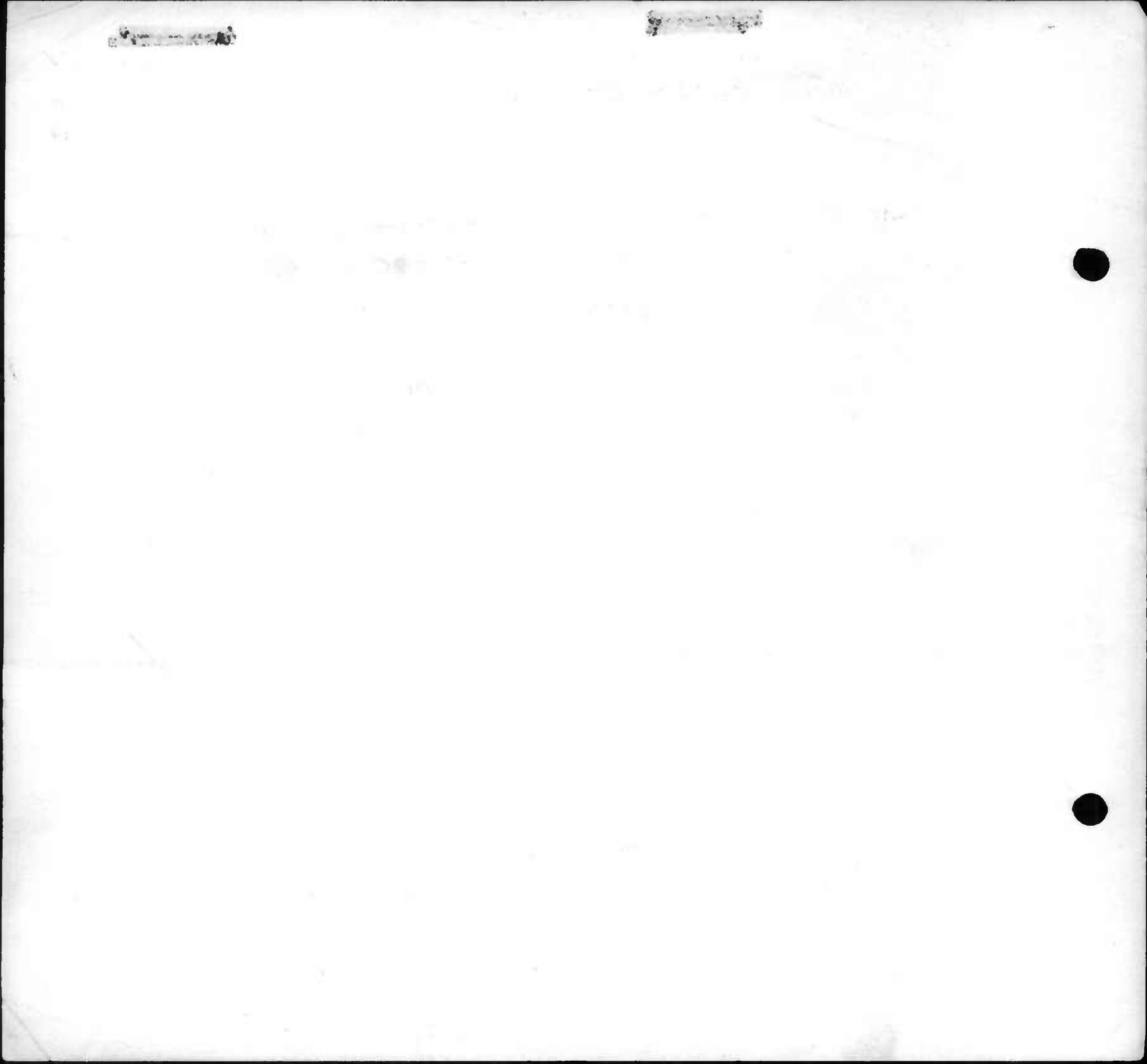


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
B-652		72-00001		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MARY ELIZA Barnes</b>		2. DATE AND HOUR OF DEATH <b>1 JAN 1972 1 45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND - BALT. CITY</b> B. COUNTY <b>805</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1901 E. CASTLE ST - 21213</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-00</b>	9. AGE (In years last birthday) <b>71</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Oxford, N. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>BOB RIDLEY</b>		14. MOTHER'S MAIDEN NAME <b>CAROLING RIDLEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN no</b>		16. SOCIAL SECURITY NO. <b>219-28-4594</b>		17. INFORMANT <b>Mary POLLOCK - SAME ADDR.</b>	
18. <b>2509 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>VENTRICULAR ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>DIABETES MELLITUS</b> (B) <b>15 years</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>323 DEC 71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ANGIENE OF L FOOT</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>22 DEC 1971</b> to <b>1 JAN 1972</b> and that (I) (we) last saw the deceased alive on <b>1 Jan 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George Curlew, MD</b>		23B. DATE SIGNED <b>1 Jan 72</b>		23C. PHYSICIAN'S NAME (Type) <b>George Curlew, MD</b>	
23D. ADDRESS <b>DEGREE</b>		23E. NAME OF REGISTRAR <b>2000</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>			
25B. NAME OF REGISTRAR <b>2000</b>		25C. FUNERAL DIRECTOR <b>1735 Hartford Ave. ADDRESS</b> <b>Marshall W. Jones, Jr.</b>			





B-650

12-00002

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

12-00002

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Earl T. Brown Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 1 72 1:19 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year 1 1 72 1:19 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/5/44		10. AGE (In years last birthday) 27	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Delores Weathers		ADDRESS 2413 S. Paca St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 1 1 72 12:40 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Found in 2300 blk Wilgrey Court		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-1-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/6/72	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert J. Fisher	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.  
JANUARY 1, 1900  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the matter mentioned therein.  
The same has been referred to the proper authorities for their consideration.  
Very respectfully,  
Your obedient servant,  
J. M. [Signature]

E-420

72-00003

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72-00003

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Lee</b> <b>Robert Ellis</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 1 72 8:23 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 1 72 8:23 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2001</b>	
9. DATE OF BIRTH <b>Nov 18-1946</b>		10. AGE (In years last birthday) <b>25</b>	
11. BIRTHPLACE (State or foreign country) <b>Orangeburg S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BOYD ELLIS</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA PINNEY</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO. <b>218-46 5967</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		18. INFORMANT <b>BRENDA ELLIS 1821 MADISON AVE</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1915 W. Lexington Street 2001</b>		22D. TIME OF INJURY (APPROX.) <b>1 1 72 6:30 P. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>1-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-6-71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>W. H. A. D. V. A. N.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>W. H. A. D. V. A. N.</b>		25D. ADDRESS <b>6802 [Address]</b>	



1

L-000 72-00004  
BIRTH NO. 68-08535

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72-00004C

1. NAME OF DECEASED (Type or Print) Reginald (Reggie) Lee		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 1 72 10:27A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2006 Harford Road		3. DATE PRONOUNCED DEAD Month Day Year 1 1 72 10:27A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 908	
9. DATE OF BIRTH 5-8-68		10. AGE (In years last birthday) 3	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert J. Lee		14. MOTHER'S MAIDEN NAME Josie Willis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert J. Lee		18. ADDRESS 2006 Harford Ave Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypoplasia of thymus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 1-2-72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 1-6-72		24C. NAME of CEMETERY or CREMATORY Balto National Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972	
25B. NAME OF REGISTRAR Robert C. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm C March	
25D. ADDRESS 928 E North Ave.			

VS 151-REV. 1/1/68

REPUBLIC OF THE PHILIPPINES

DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

MANILA

January 1, 1900

TO THE HONORABLE COMMISSIONER OF THE LAND OFFICE

AND TO THE HONORABLE SECRETARY OF THE TREASURY

SIR:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully, Sir, your obedient servant,

JOSE P. RIVERA

Secretary

Office of the Secretary

Department of Agriculture

Manila

January 1, 1900

TO THE HONORABLE COMMISSIONER OF THE LAND OFFICE

AND TO THE HONORABLE SECRETARY OF THE TREASURY

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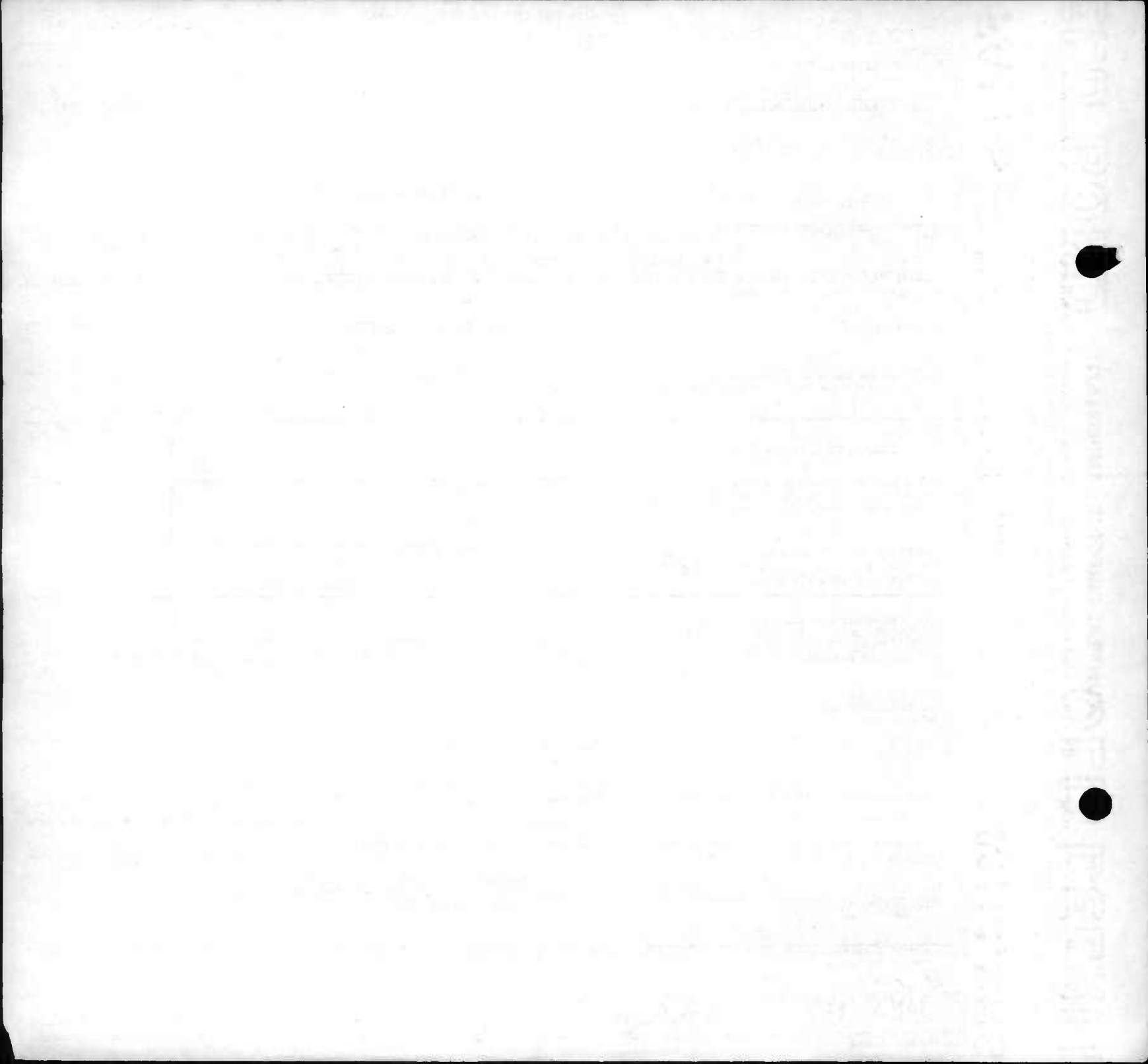
SIR:



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-00005</u>	
S-455		72-00005		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SOLOMON, GEORGE L.</u>		2. DATE AND HOUR OF DEATH <u>8-2-72</u> <u>8:50 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Finai Hosp. of Baltimore, Inc.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>1510</u> B. COUNTY  C. CITY OR TOWN  D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER <u>4025 Boorman Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>N N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-26</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Cloud Solomon</u>		14. MOTHER'S MAIDEN NAME <u>Helen Wilson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>241-32-7478</u>		17. INFORMANT <u>Helen E. Solomon</u> ADDRESS <u>4025 Boorman Ave</u>	
18. <u>20571 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hepato-Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Myeloperoxidase Leukemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>20 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pneumonia</u>				<u>8 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Veneranda C. Gerasmio</u> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/2/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>VENERANDA C. GERASMIO M.D.</u> DEGREE		23D. ADDRESS <u>Finai Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-7-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>LITTLETON, N.C.</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Valerie E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Wm G MARCH</u> ADDRESS <u>928 E NORTH AVE</u>					

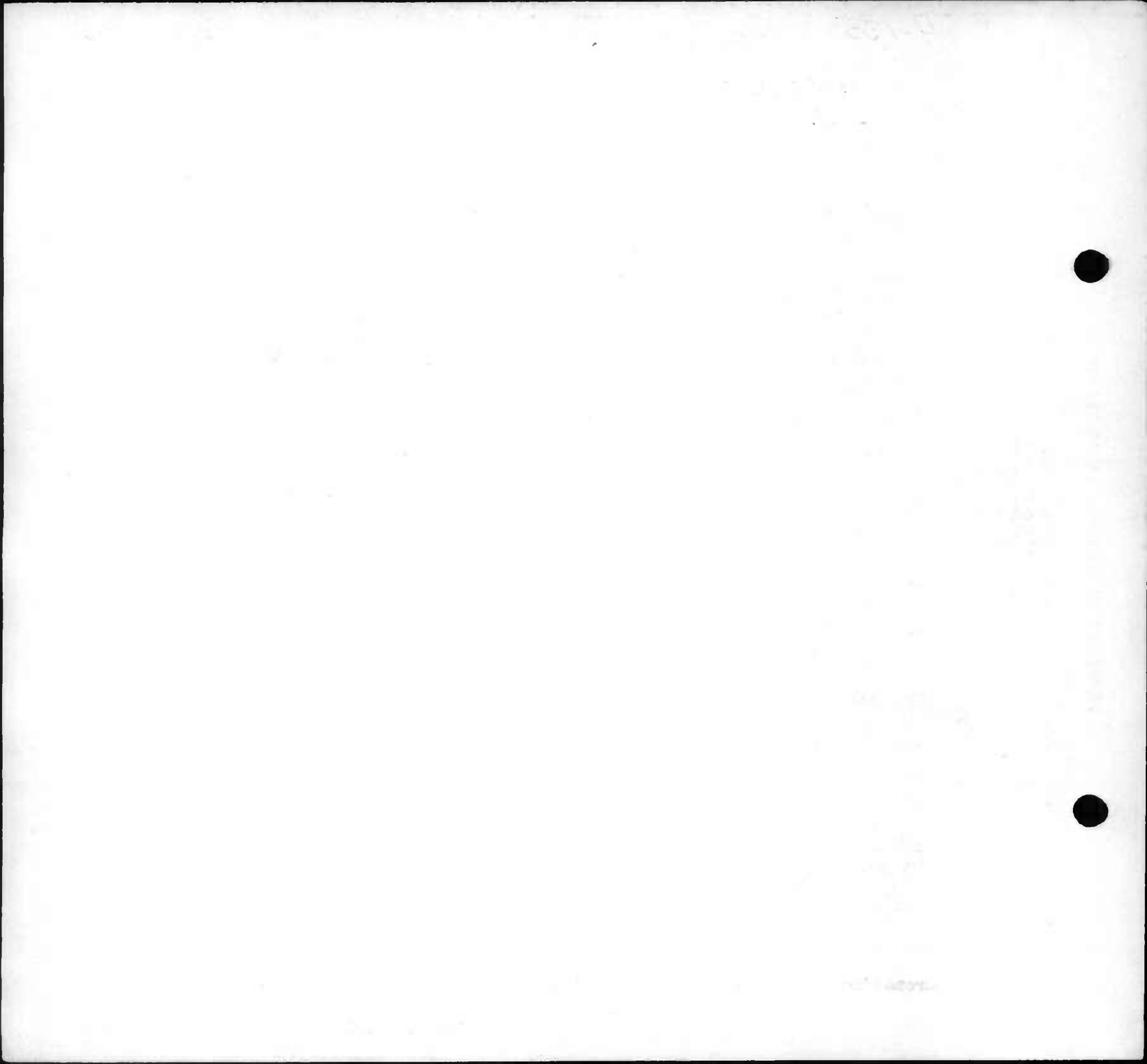




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>H-635</span> <span>22-00006</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>22-00006</u>	
BIRTH NO. <u>1</u>		2. DATE AND HOUR OF DEATH <u>1 JANUARY 1972</u> <u>8:55 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>HARTMAN, JOHN</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2834</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>US PUBLIC HEALTH SERVICE Hosp.</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>27</u>		E. STREET AND NUMBER <u>504A Glen Allen Dr.</u>	
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 MAR. 1918</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>P.I</u>	9. AGE (In years last birthday) <u>53</u>
13. FATHER'S NAME <u>ALBERT HARTMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATALINA ABANES</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>106 18 7605</u>	
17. INFORMANT <u>Hosp. Admission Manifest</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY Insufficiency</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>5 hrs</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1 WEEK</u> <u>2 years</u> (B) <u>BILATERAL PNEUMONIA</u> (C) <u>LYMPHOSARCOMA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>1 WEEK</u> <u>2 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>Dec 15</u> 19 <u>71</u> to <u>JAN 1</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>JAN 1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard S. Kaplan MD</u>		23B. DATE SIGNED <u>1/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD S. KAPLAN MD</u>		23D. ADDRESS <u>3100 WYMAN PARK DR. BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>1/5/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 8 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>	25C. FUNERAL DIRECTOR <u>Witzke, J</u>
		ADDRESS <u>1630 Edmondson Avenue 21228</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		72-00007	
1. NAME OF DECEASED (Type or Print) <b>ELLIS, WILLIAM</b>				2. DATE AND HOUR OF DEATH <b>01/01/72 10:00AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>17 LOCUST DRIVE 21228</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/22/13</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>STEPHEN ELLIS</b>				14. MOTHER'S MAIDEN NAME <b>MARY KARDOS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW2</b>		16. SOCIAL SECURITY NO. <b>143 03 6133</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL BALTO MD 21229</b>			
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Esophageal Cancer with Coarctation</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 - 3 Mo</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>12/1/71</b> 19__ to <b>01/01/72</b> 19__ that (X) (we) last saw the deceased alive on <b>01/01/72</b> 19__ and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XX) (X) view the body after death.							
23A. SIGNATURE <b>Raymond Bahr</b>				23B. DATE SIGNED <b>1/1/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>RAYMOND BAHR, M.D.</b>				23D. ADDRESS <b>MD. 21229 304 WILKENS &amp; PINEHEIGHTS AVE., BALTO.,</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 8 1972</b>		25B. NAME OF REGISTRAR <b>Reed E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Edmondson Avenue</b>		ADDRESS <b>21228</b>	

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22-00008

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

22-00008

BIRTH NO.

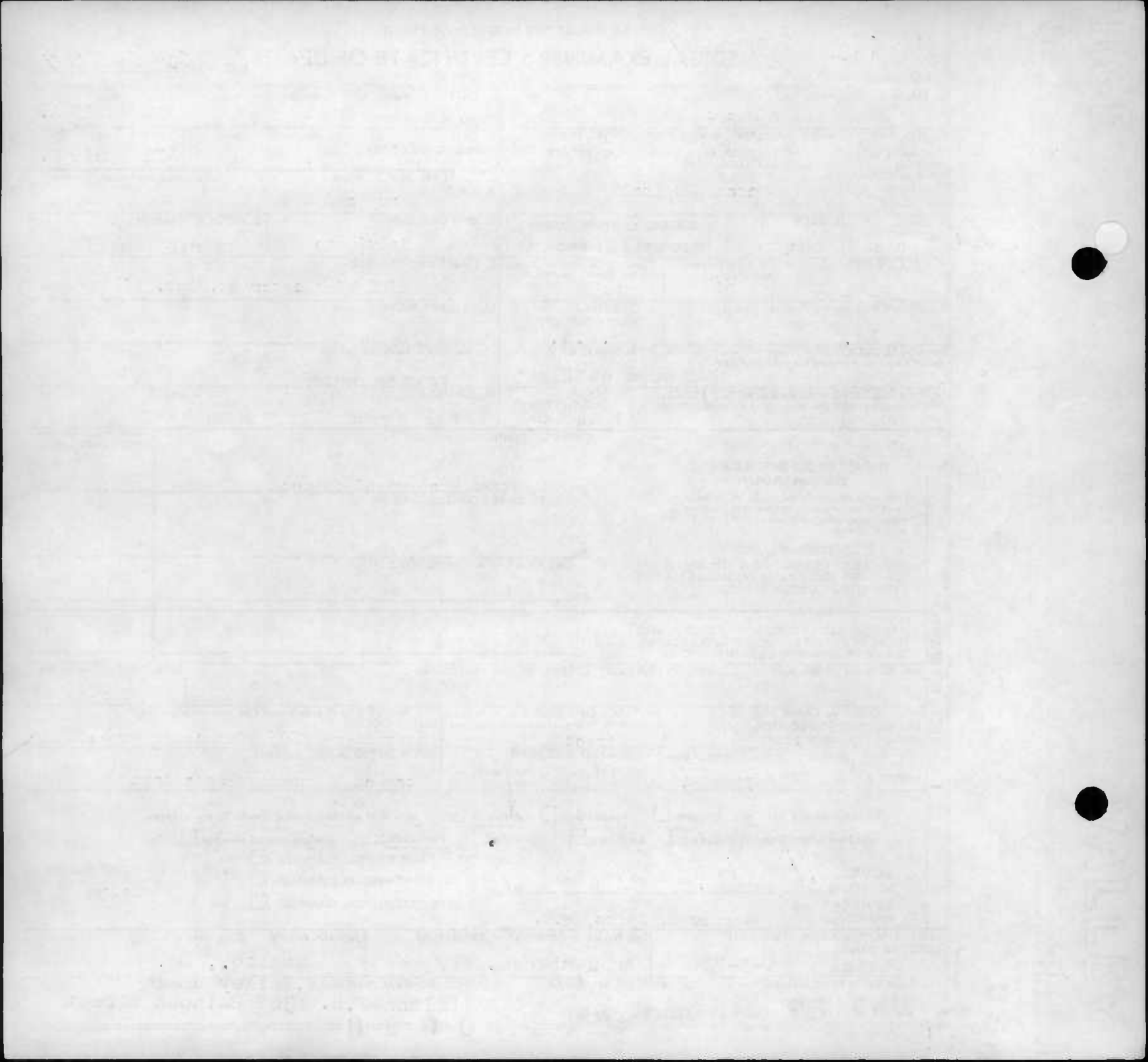
1. NAME OF DECEASED (Type or Print) <b>L. Leonard Roane</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>1</b> Year <b>72</b> Hour <b>7:00 P.M.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>1</b> Year <b>72</b> Hour <b>7:00 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1603</b>	
9. DATE OF BIRTH <b>11-13-35</b>		10. AGE (In years last birthday) <b>36</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		15. MOTHER'S MAIDEN NAME <b>Mattie Brown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO. <b>220-30-5360</b>	
18. INFORMANT <b>Shirley Roane</b>		ADDRESS <b>1106 N. Mount St.</b>	
19. <b>5-71-8 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <b>Fatty alteration of liver</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner H. Spitz</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner H. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Mary-Elizabeth Law</b>		ADDRESS <b>802 Madison Ave.</b>	

1/10/72 - Correction for m from funeral director.

*XBC.*

W-520 22-00009 BALTIMORE CITY HEALTH DEPARTMENT  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 22-00009

BIRTH NO.		1. NAME OF DECEASED (Type or Print) John Weems		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 1 Year 72 Hour 1:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month 1 Day 1 Year 72 Hour 1:10 A.M.		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1605	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-9-46		10. AGE (In years last birthday) 25	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Calvin Weems		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chevrolet Plant		15. MOTHER'S MAIDEN NAME Floretta Bush	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218448064		18. INFORMANT ADDRESS Cheryl Weems same	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E966X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Stab wound of neck DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? in front of 2505 Winchester Street 1605	
22D. TIME OF INJURY (APPROX.) 1 1 72 12:40Am.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-1-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk/ Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 348 Calhoun Street	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>22-00010</u>	
<b>BIRTH NO.</b> <u>N-200</u>		<b>72-00010</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <u>HAROLD NISKEY</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>1-1-72</u> <u>12:19 P.M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL</u> <u>38</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution's residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1606</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2733 PROSPECT STREET</u>		
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-8-13</u>	<b>9. AGE</b> (In years last birthday) <u>58</u>	<b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>XXX Md.</u>	
<b>13. FATHER'S NAME</b> <u>JOHN HAROLD</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>EVELYN NISKEY</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Constance Harris same</u>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>486X14162.1</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> - <u>Immed.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>RESPIRATORY ARREST</u> <u>Immed.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Pneumonia</u> <u>10d.</u> <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Cancer of lungs</u> <u>10 months</u>					
<b>19A. DATE OF OPERATION</b> <u>1 Tracheostomy</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>Local Anesth.</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12-27</u> <u>1971</u> <b>to</b> <u>1-1</u> <u>1972</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1-1</u> <u>1972</u> <b>and that (in my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Robert A. Lessey</u>			<b>23B. DATE SIGNED</b> <u>1-1-72</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>ROBERT A. LESSEY</u>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>24B. DATE</b> <u>12-5-72</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Mt. Auburn Cem.</u>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 8 1972</u>			<b>25B. NAME OF REGISTRAR</b> <u>Robert A. Lessey</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Bailey</u>
<b>ADDRESS</b> <u>1348 Calhoun St.</u>					

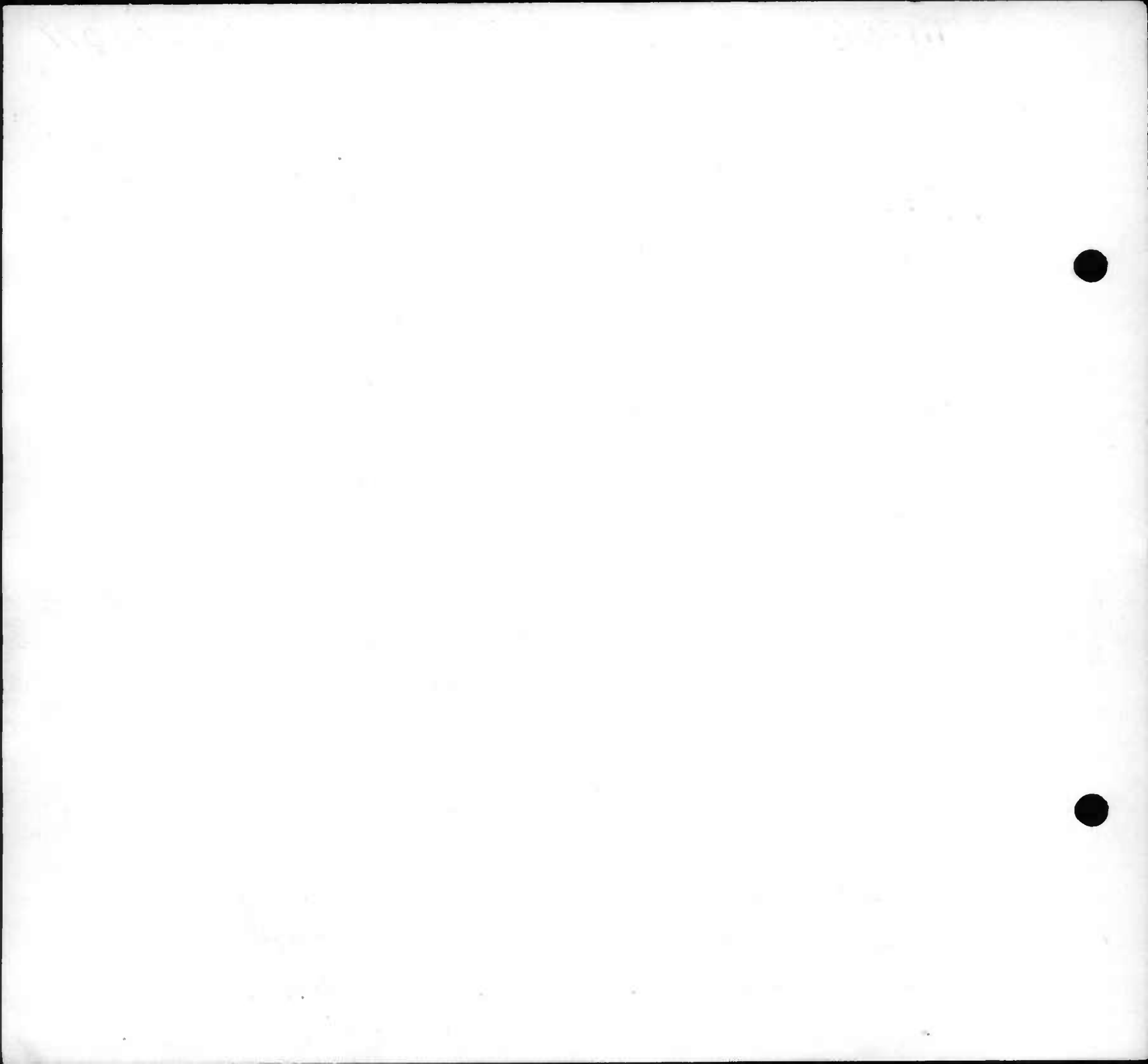
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72-00011</u>	
<b>BIRTH NO.</b> <u>M-300</u>		<b>DATE AND HOUR OF DEATH</b> <u>1-2-72, 9:45</u> <u>9:45</u> A.M.			
<b>1. NAME OF DECEASED</b> (Type or Print) <u>William M. Moody</u>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND</u> <u>8 HOSPITAL, BALTIMORE</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>905</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2608, Kirk Ave, Balto. Md 21218</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>NEGRO</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-27-02</u>	<b>9. AGE</b> (In years last birthday) <u>69</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) 
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) 		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <u>VIRGINIA</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Joseph Moody</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Roxanne</u>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-07-2056</u>		<b>17. INFORMANT</b> <u>Ruth Pettie</u> <u>same</u>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.1 I</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Pontine Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Myocardial Ischemia</u> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Chronic Lung disease</u>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>3-4 m</u>	
<b>19A. DATE OF OPERATION</b> 		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) 		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) 		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) 	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) 		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> 	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/21/1971</u> <b>to</b> <u>1/2/1972</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/1/1972</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>M. S. H. Almarashi</u>				<b>23B. DATE SIGNED</b> <u>1/2/72</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Dr. M. S. H. ALMARASHI MD</u>				<b>23D. ADDRESS</b> <u>UNIV. OF MD. Hospital</u>	
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>1-5-72</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Mt. Auburn Cem.</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Balto., Md.</u>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 3 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor, MD</u>		<b>25C. FUNERAL DIRECTOR</b> <u>V. Bailey</u>	
<b>ADDRESS</b> <u>1348 Calhoun St.</u>					



B-430

72-00012

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72-00012

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID William Bolt		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 1 72 12:15P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2126 E. Lombard Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 12:15P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH AUG 9 1906		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GREENVILLE BOLT		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 105	
15. MOTHER'S MAIDEN NAME LARA UNK.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 831-42-3328		18. INFORMANT AMANDA E BOLT 2126 E LOMBARD ST.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-2-72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 5 1972	
24C. NAME OF CEMETERY or CREMATORY MT CARMEL CEM.		24D. LOCATION (City, town, or county) (State) ODONNELL ST BALD MD	
25A. DATE REC'D BY HEALTH DEPT JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST		25D. ADDRESS	

Aug 1 1902

Penitentiary

Chapman

10

State Prison

12

Chapman

10

Aug 1 1902

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-00013</u>	
C-162				72-00013	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William Joseph Cierpisz, Sr.</u> <u>A/k as CIEPRISZ, WILLIAM Joseph, Sr.</u>			2. DATE AND HOUR OF DEATH <u>1/1/72</u> <u>8:00</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>33</u> <u>JOHNS HOPKINS</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>601</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>129 N. KENWOOD AVE.</u>		
5. SEX <u>MALE</u>	6. RACE <u>White</u> <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-11-92</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Foreman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>City of Baltimore</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Michael CIEPRISZ [Michael Cierpisz]</u>			14. MOTHER'S MAIDEN NAME <u>Anastasia <del>Kowndowski</del> Lewandowski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I, Navy</u> <u>21</u>			16. SOCIAL SECURITY NO. <u>4-40-6951</u>		
17. INFORMANT <u>Mr. William J. Cieprisz, 3141 Chesterfield</u>			ADDRESS <u>Av.</u>		
18. <u>43691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u> (B) <u>Brainstem Stroke</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>11 days</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>71</u> to <u>1/1</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jerome E. Kurant MD.</u>			23B. DATE SIGNED <u>1/1/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Jerome E. Kurant</u>			23D. ADDRESS <u>Johns Hopkins</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/5/72</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF FUNERAL HOME <u>72000</u>		25C. FUNERAL DIRECTOR <u>M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</u>	

11/15

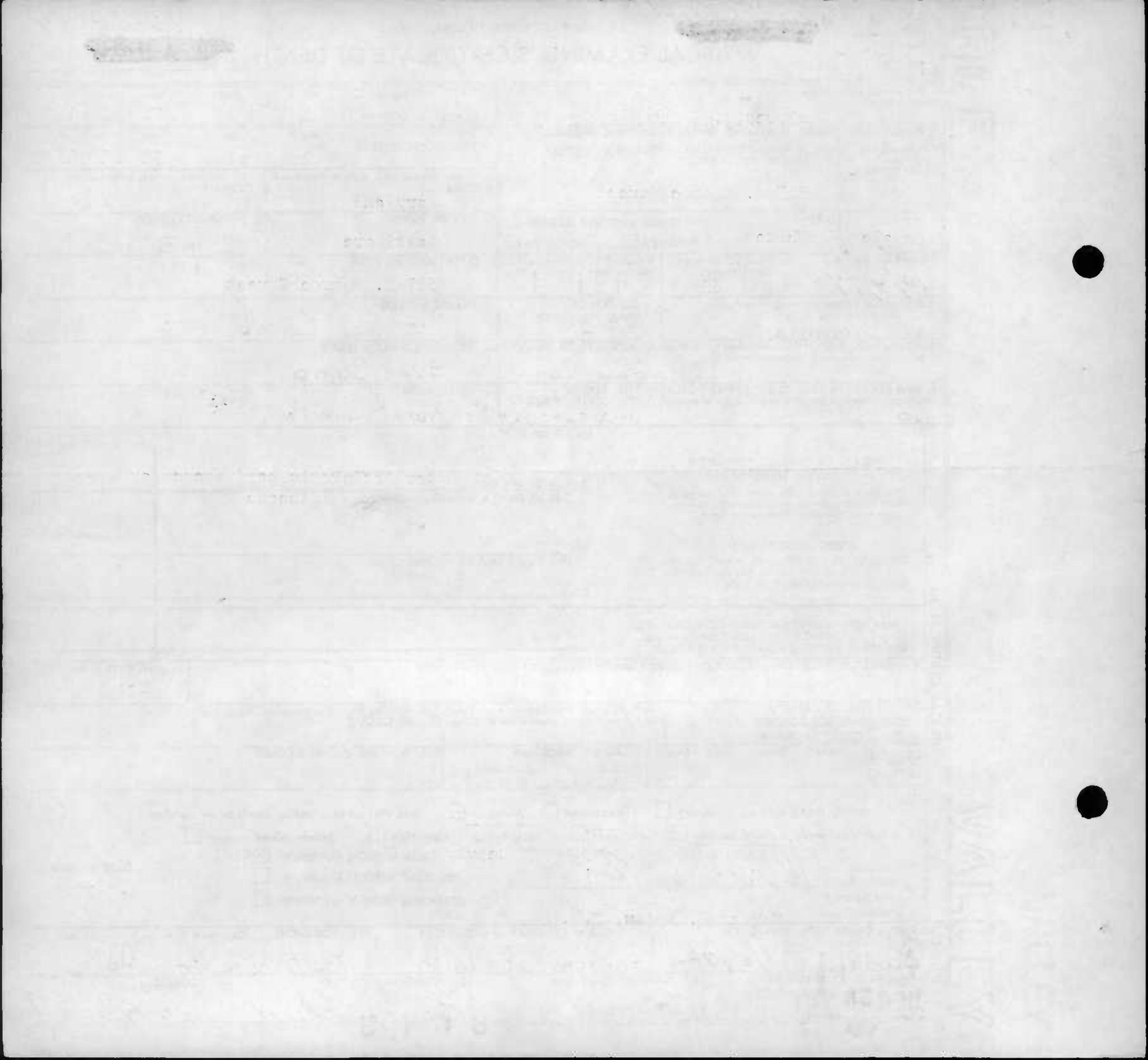


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

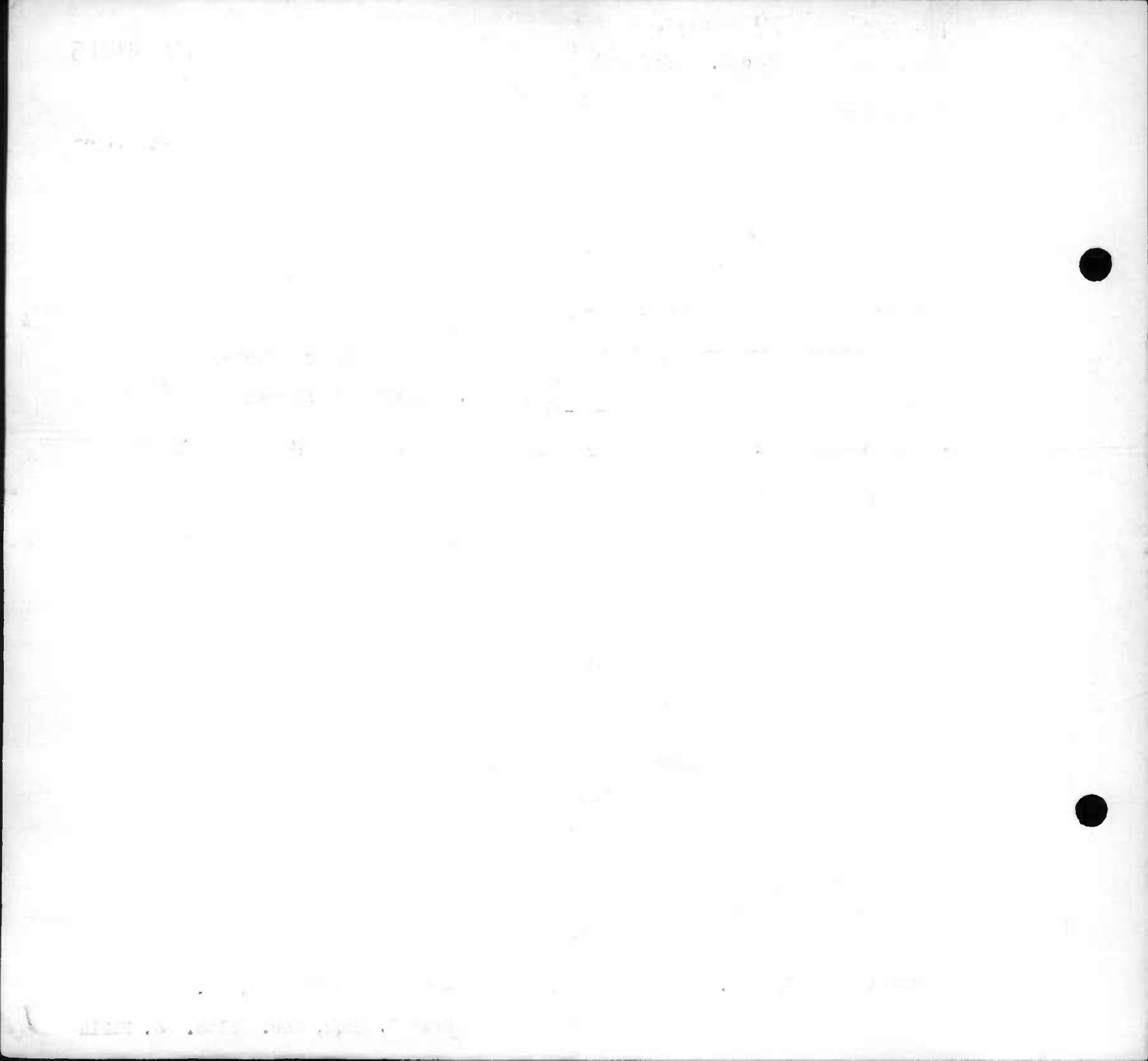
1. NAME OF DECEASED (Type or Print) <b>Dolores E. Smith</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 1 72 10:45 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>527 S. Monroe Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 1 72 10:45 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1903</b>	
9. DATE OF BIRTH <b>10/9/17</b>		10. AGE (In years lost birthday) <b>54</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>Md. Glass Co.</b>	
15. MOTHER'S MAIDEN NAME <b>Eva Camp</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>236-24-7853</b>		18. INFORMANT <b>Mr. Albert Smith</b>	
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1 1 72 10:45 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner H. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>1-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/5/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Sp. L. Schuch, Jr.</b>		ADDRESS <b>101 Frederick Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-245		72 00015		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 508,308	
BIRTH NO.		(Leo J. Deckelman)		CERTIFICATE OF DEATH		72 00015	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LEO J. DECKELMAN				JAN 2, 1972 8:45 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
42 SINAI HOSPITAL				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4403 COOK AVE. #6			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
M	C W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/23/14	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Foreman N/A				General Motors		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Deckelman				Anna Necker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No N/A				216-01-7446		Mrs. Katherine Deckelman	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I				CARCINOMA OF LUNGS		FEW MONTHS	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CARDIO-PULMONARY ARREST		IMMEDIATE	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				VENTILATION		FEW DAYS	
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
MAY 7, 1971				CANCER OF LUNGS		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from DEC 31 19 71 to JAN 2, 19 72 that (I) (we) last saw the deceased alive on JAN 2, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
[Signature]				1/2/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CARLTON T. RIZON, M.D.				SINAI HOSPITAL RES. QTRS.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/6/72.		Gardens of Faith Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 4 1972		R. R. E. [Signature]		Leonard J. Ruck, Inc.		Balto. Md. 21214	



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72 00016

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00016

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>James Eugene Ebert Jr</b> <b>James E. Ebert, Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 1 72 11:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>4013 Woodlea Avenue</b> <b>Woodlea</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 11:00 A.M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2741</b>	
9. DATE OF BIRTH <b>July 18, 1954</b>		10. AGE (In years last birthday) <b>17</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Dorothy Keller</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>217-64-0078</b>		18. INFORMANT <b>Mr James E Ebert Sr</b>	
19. CAUSE OF DEATH <b>30491</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ADDRESS <b>Same</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/5/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Blair E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc.</b>		ADDRESS <b>Baltimore, Md</b>	

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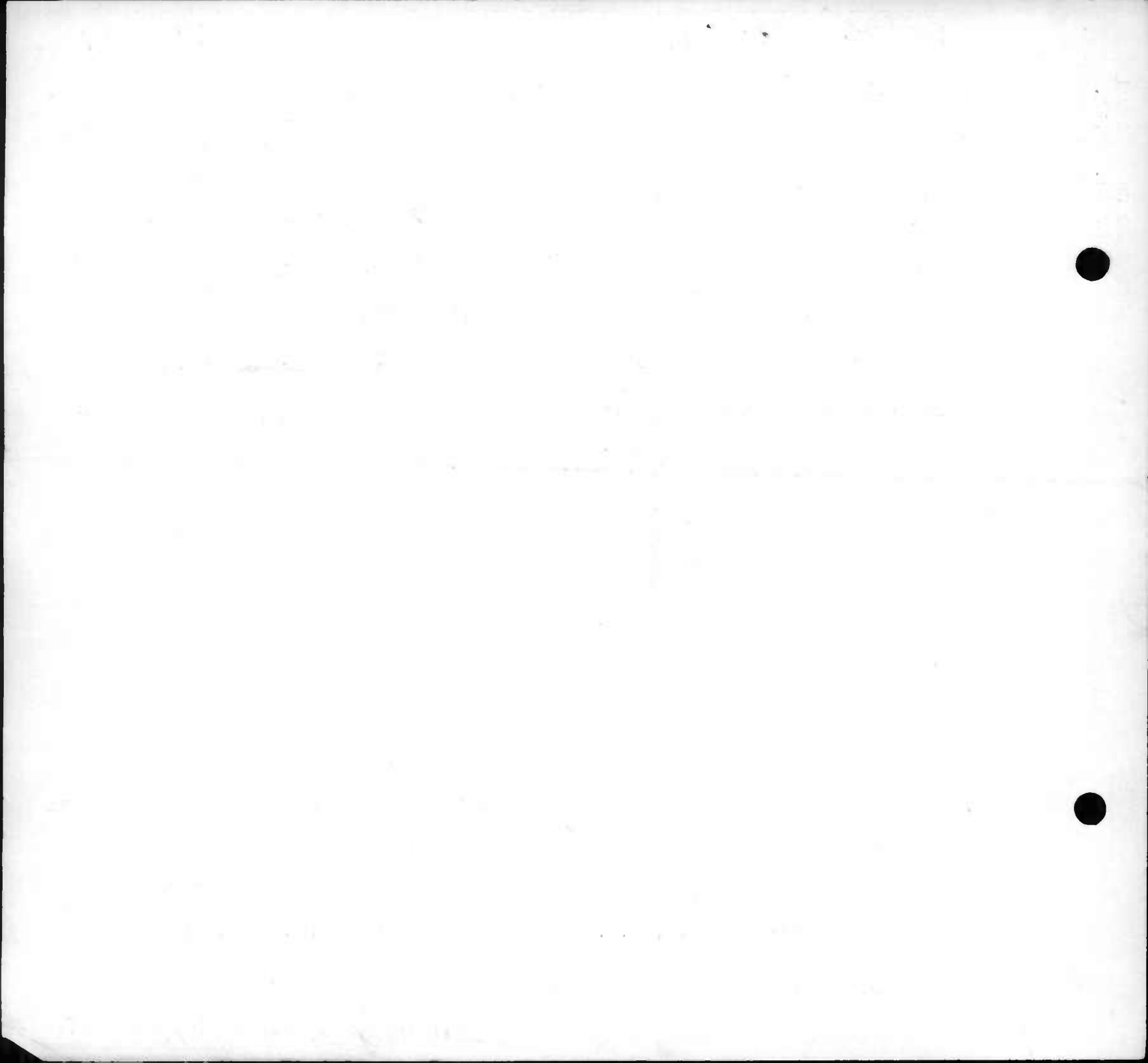
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530		72 00017		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00017	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) JOHANN JOYCE BENNETT (GREBOS)				2. DATE AND HOUR OF DEATH 1 JAN 72 8 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND - BALTO CITY 702 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 2417 McELDERY ST.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-29-45	9. AGE (In years last birthday) 26	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS				10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES GREBOS				14. MOTHER'S MAIDEN NAME MARIE <del>HECK</del> HECK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN No				16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT ADDRESS EMMA WILKE - 2335 Jefferson St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACIDOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC RENAL FAILURE HEAD INJURY				CAUSE OF DEATH CARDIAC ARRHYTHMIA A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACIDOSIS B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC RENAL FAILURE C) HEAD INJURY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 YEARS 4 WEEKS	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 12/4/71 ?				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Auto accident	
22. I certify that (I) (this hospital) attended the deceased from 1 JAN 19 72 to 1 JAN 19 72 that (I) (we) lost saw the deceased alive on 1 JAN 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George Curlin M.D.				23B. DATE SIGNED 1 Jan 72		23C. PHYSICIAN'S NAME (Type) GEORGE CURLIN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 1-5-72		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO, MD.				25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972			
25B. NAME OF REGISTRAR Charles J. [REDACTED]				25C. FUNERAL DIRECTOR ADDRESS [REDACTED] - 2334 Jefferson St.			





# FUNERAL DIRECTOR: IMPORTANT

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W-306 72 00018				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00018 REG. NO. _____	
1. NAME OF DECEASED (Type or Print) <b>WHITE GRACE E.</b>				2. DATE AND HOUR OF DEATH <b>JAN - 2nd 1972 7.25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>4 CERTIFICATE AMENDED UNION MEMORIAL HOSPITAL 2-2-72</b>				C. CITY OR TOWN <b>GLEN BURNIE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-22-10</b>		9. AGE (In years last birthday) <b>61</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE RN.</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>KENT TAYLOR EVANS (D)</b>			
14. MOTHER'S MAIDEN NAME <b>DELTA LANCE (D)</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No Yes World War II</b>			
16. SOCIAL SECURITY NO. <b>212-32-1468</b>				17. INFORMANT <b>Hosp Records</b>			
18. <b>799.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30' MIN.</b>	
				(B) TERMINAL METASTASIS CANCER DUE TO, OR AS A CONSEQUENCE OF:		<b>5 YEARS</b>	
				(C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Juan H. Llanow H.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-2-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SLAUGHTER, DONALD H.D.</b>				23D. ADDRESS <b>1010 ST. PAUL ST. BALTIMORE, MARYLAND.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>1-5-72</b>		<b>Barbour Memorial Park</b>		<b>BELINGTON W. VA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Bailey, R.D.</b>		25C. FUNERAL DIRECTOR <b>Wm Cook-Brooks Towson, Inc. Towson, Md.</b>	

2-2-1972 - Correction from Funeral Director - John M. Stemple

HRS

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
C-615 72 00019						72 00019	
1. NAME OF DECEASED (Type or Print) EDWARD E. CORBIN				2. DATE AND HOUR OF DEATH January 1, 1972 1:55 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines Belvedere				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300			
5. SEX Male 6. RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH August 1, 1893		9. AGE (in years lost birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian				10B. KIND OF BUSINESS OR INDUSTRY Tractor Manufacturer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Corbin				14. MOTHER'S MAIDEN NAME Amelia Turner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1				16. SOCIAL SECURITY NO. 217-03-8601		17. INFORMANT Joseph E. Corbin Same as # 4 E	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute	
(B) <i>Arteriosclerotic CVD</i> DUE TO, OR AS A CONSEQUENCE OF:				(C) _____		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-12 1971 to 1-1 1972 that (I) (we) last saw the deceased alive on 12-31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leon A. Kockman				23B. DATE SIGNED 1-3-72		23C. PHYSICIAN'S NAME (Type) Leon A. Kockman	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1-4-71		24C. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery		24D. LOCATION (City, town, or county) (State) Cockeysville Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks		Towson, Inc. Towson, Maryland	

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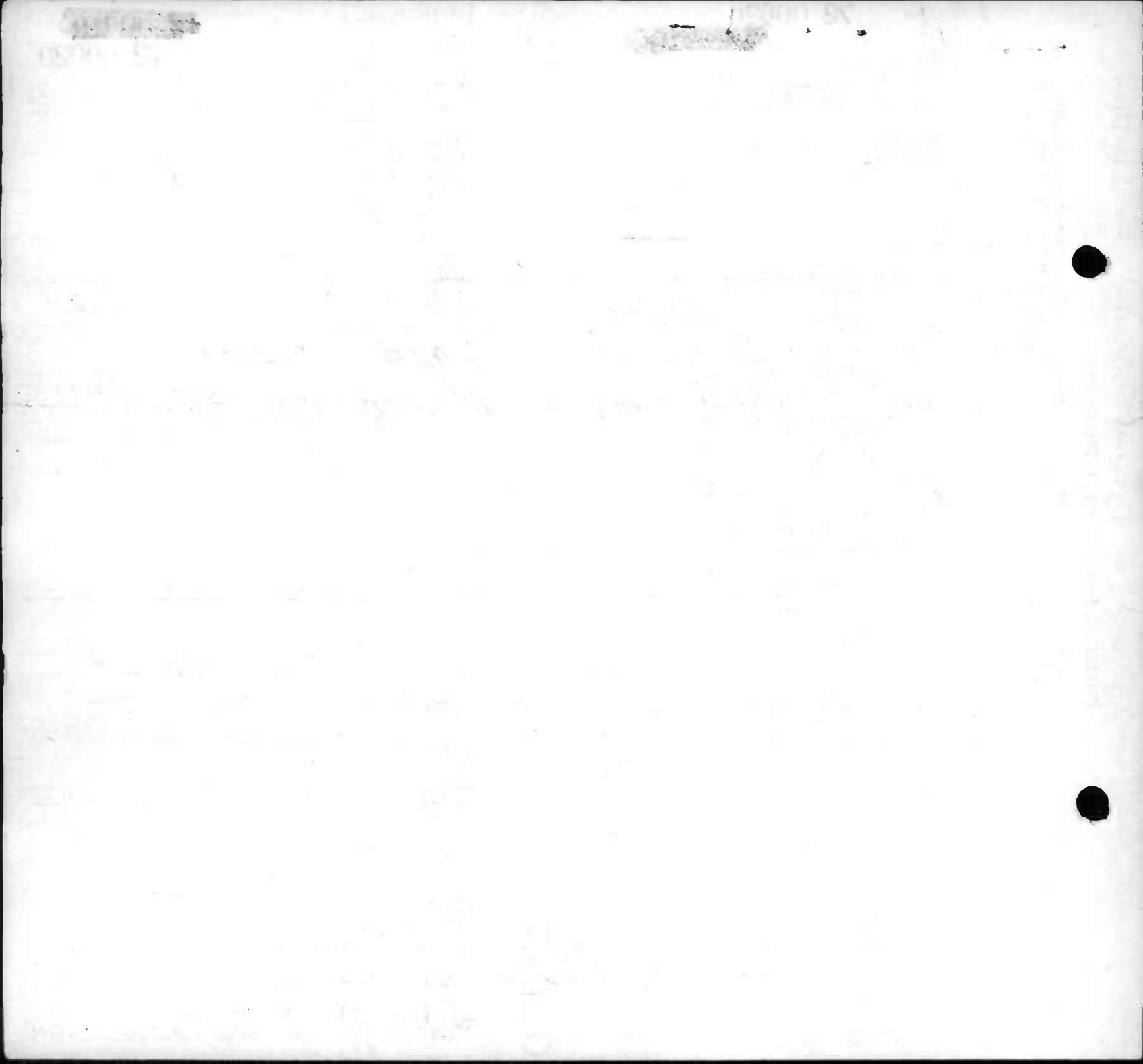
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## FUNERAL DIRECTOR: IMPORTANT

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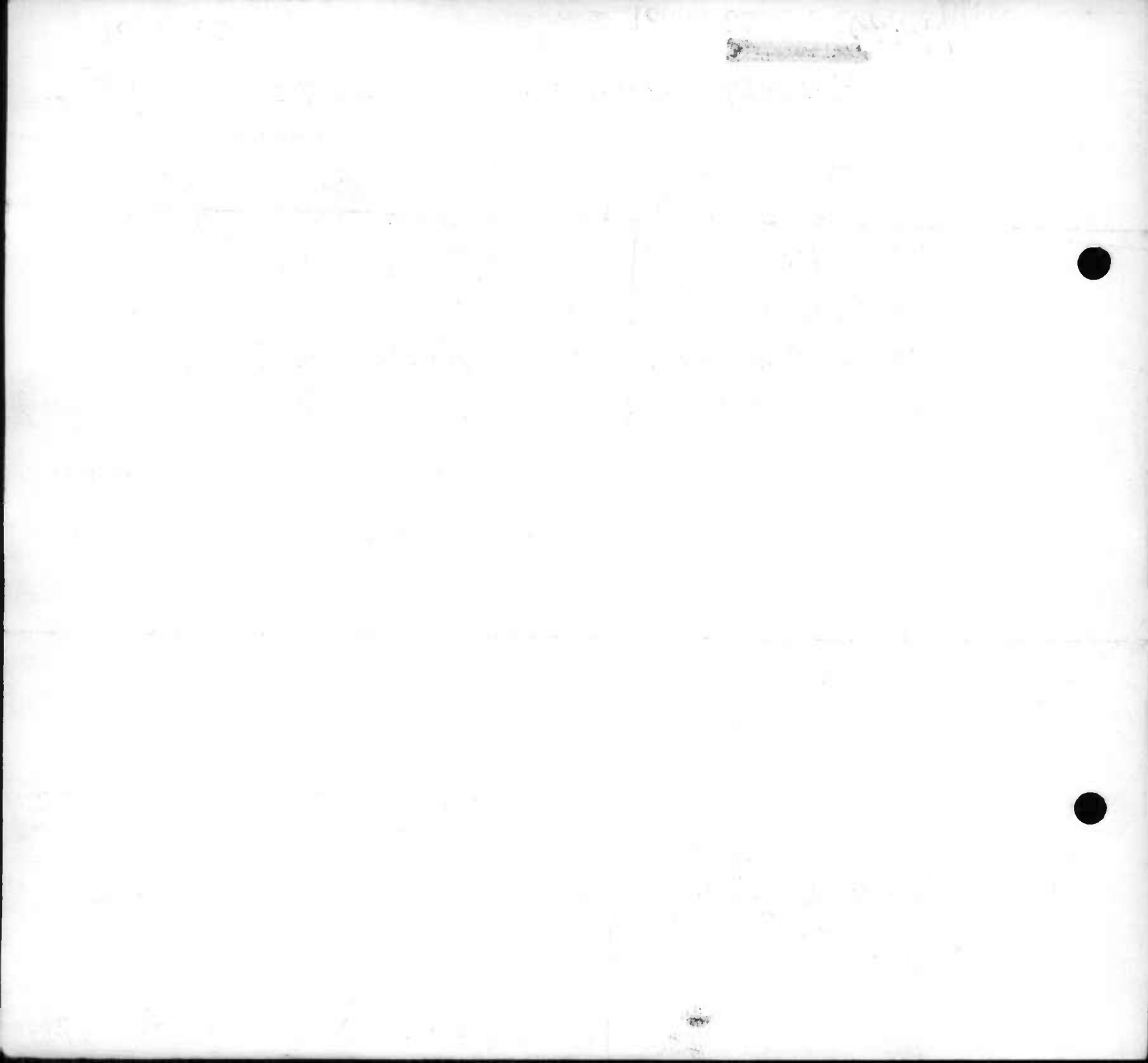
P-62472 00020		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00020	
BIRTH NO.		CERTIFICATE OF DEATH		72 00020	
1. NAME OF DECEASED (Type or Print) <del>PURCELL</del> PURCELL, WILLIAM C.		2. DATE AND HOUR OF DEATH Jan 1 1972 4 <sup>35</sup> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1206			
FULL NAME OF HOSPITAL OR INSTITUTION 44 The Union Memorial Hospital 33rd & Calvert Street.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 23 E, 21st St			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/12/22	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Oil Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Christopher M. Purcell		14. MOTHER'S MARDEN NAME ANITA HART			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 220-05-0981		17. INFORMANT Mrs. Anna S. Wright	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) Brain Contusion		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brain Contusion (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 hrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION Dec 30 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Craniectomy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) In home		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City 12-06	
21D. TIME OF INJURY (APPROX.) Dec 30 1971 18h		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fall down stairs	
22. I certify that (I) (this hospital) attended the deceased from Dec 30 1971 to Jan 1 1972 that (I) (we) last saw the deceased alive on Jan 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Teh-ching Wang		23B. DATE SIGNED JAN 1, 1972			
23C. PHYSICIAN'S NAME (Type) TEH-CHING WANG MD		23D. ADDRESS 3122 Guilford Ave. Baltimore MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mortuary	
24D. LOCATION (City, town, or county) (State) AA. Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie Md.			
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

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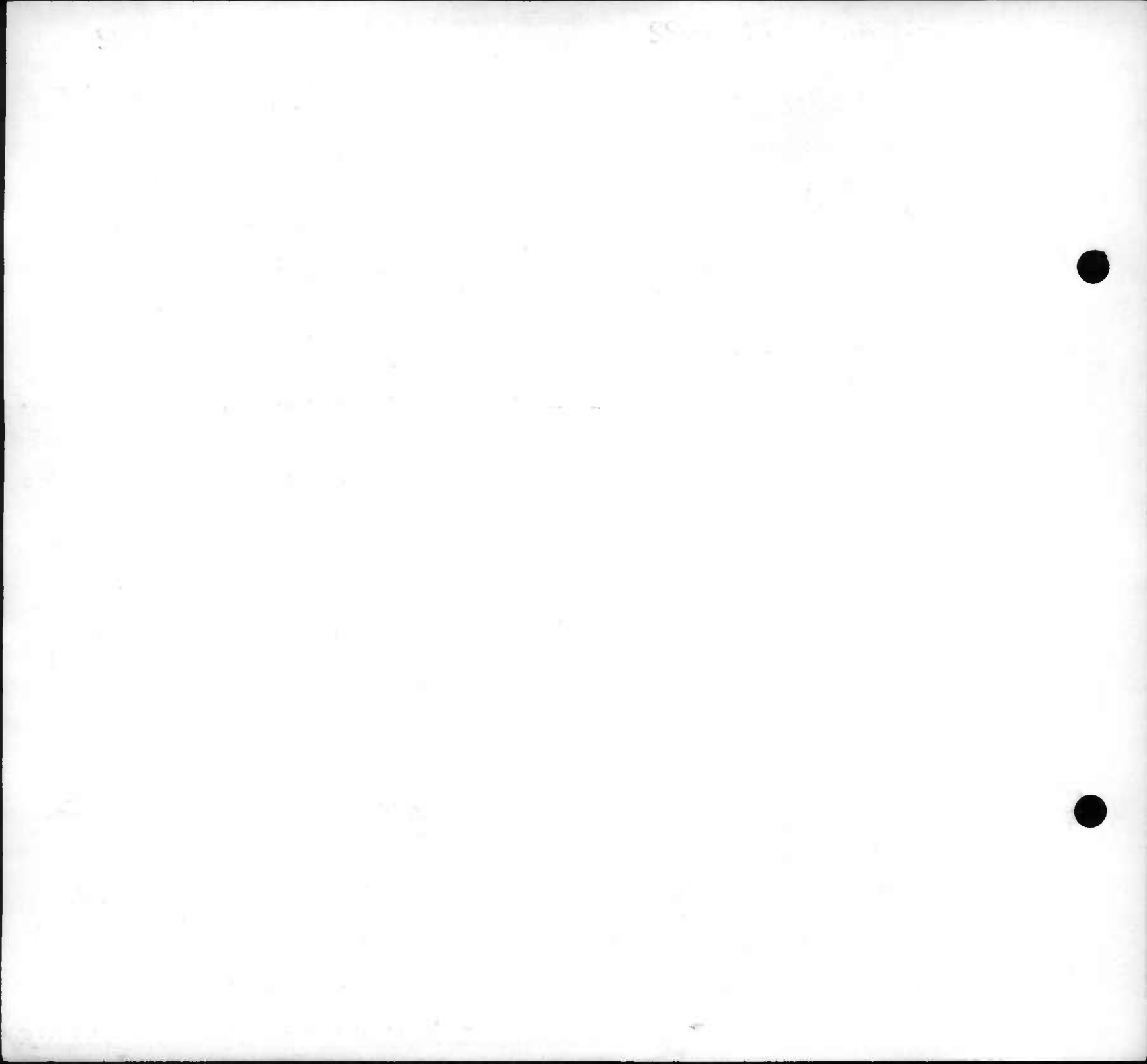
M-440 72 00021		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00021	
1. NAME OF DECEASED (Type or Print) <b>MALOOLY WILLIAM J - JR</b>		2. DATE AND HOUR OF DEATH <b>1/1/72 9:35 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSP</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>4445 Ebenezer Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/29</b>	9. AGE (in years last birthday) <b>42</b>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CTP Telephone Co</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WM. J. MALOOLY, SR.</b>		14. MOTHER'S MAIDEN NAME <b>ANNA HIGGINS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1-3-51 to 11-29-54</b>		16. SOCIAL SECURITY NO. <b>215-28-4721</b>		17. INFORMANT <b>MRS MARGARET MALOOLY</b> ADDRESS <b>4445 Ebenezer Rd</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL EDEMA</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL EDEMA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>BRAIN TUMOR</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>BRAIN TUMOR</b>		<b>1 year</b>	
(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>NONE</b>			
19A. DATE OF OPERATION <b>Dec 30 71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN TUMOR</b>		20A. AUTOPSY? (Yes or No) <b>Yes Brain only</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 28 1971</b> to <b>1/1 1972</b> that (I) (we) last saw the deceased alive on <b>1/1 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Gunduz Guicer MD</b>		23B. DATE SIGNED <b>1/1/72</b>		23C. PHYSICIAN'S NAME (Type) <b>GUNDOZ GUICER</b>	
23D. ADDRESS <b>JOHNS HOPKINS</b>		24A. FUNERAL REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>1-4-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>CHAS F EDWARDS</b> ADDRESS <b>8802 Hartford Rd</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-652 72 00022		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00022	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>FRANK HARRINGTON</b>		2. DATE AND HOUR OF DEATH <b>1/2/72 2 25 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>U. of Md. Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1601</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1228 W. Mosher ST</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/13</b>	9. AGE (In years lost birthday) <b>58</b>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Cliff Harrington</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>240-12-8686</b>		17. INFORMANT ADDRESS <b>Mr Willie Harrington, 2042 Linden Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hepatic Cirrhosis 20 to Cirrhosis</b>		<b>2 weeks</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Possible Subarachnoid Hemorrhage</b>		<b>1 week</b>	
		(C) <b>Pulmonary Tuberculosis</b>		<b>mos.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> 19 <b>71</b> to <b>1/2</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph Sappington</b>		23B. DATE SIGNED <b>1/2/72</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH SAPPINGTON, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/6/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Hamlet</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Huber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Adolphus Halstead 1206 W North Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00023	
CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>0-163</u>		1. NAME OF DECEASED (Type or Print) <u>HARRY OVERDICK</u>			
2. DATE AND HOUR OF DEATH <u>1-2-72</u>		7 <sup>30</sup> PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		A. STATE <u>MD</u>		B. COUNTY <u>203</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
48		E. STREET AND NUMBER <u>Bolton Hill Nursing Home Lafayette &amp; John St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-19</u>	9. AGE (In years last birthday) <u>60</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marine</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>GEORGE OVERDICK</u>		14. MOTHER'S MAIDEN NAME <u>CHARA SLURZENSKI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-12-2786</u>		17. INFORMANT <u>ELEANOR KOZLOWSKI</u> ADDRESS <u>520 S. DUNDALK ST.</u>	
18. <u>150X1</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Carcinoma of the esophagus, suspected</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>Secondary aspiration pneumonia 2 weeks</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
II		(C) <u>Advanced cerebral vascular d. acute + chronic peptic ulcer disease</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At <input type="checkbox"/> Work Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>10-22-1971</u> to <u>1-2-1972</u> that (I) (we) last saw the deceased alive on <u>1-2-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael P. Buchness M.D.</u>		23B. DATE SIGNED <u>1-2-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael P. Buchness M.D.</u>	
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23D. ADDRESS <u>Maryland General Hospital.</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-6-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROARY CEM</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county) <u>DUNDALK, MARYLAND</u>		24E. LOCATION (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>		25B. NAME OF REGISTRAR <u>John E. Galt, M.D.</u>		25C. FUNERAL DIRECTOR <u>John M. Weber, Sons Inc. S. Chester</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

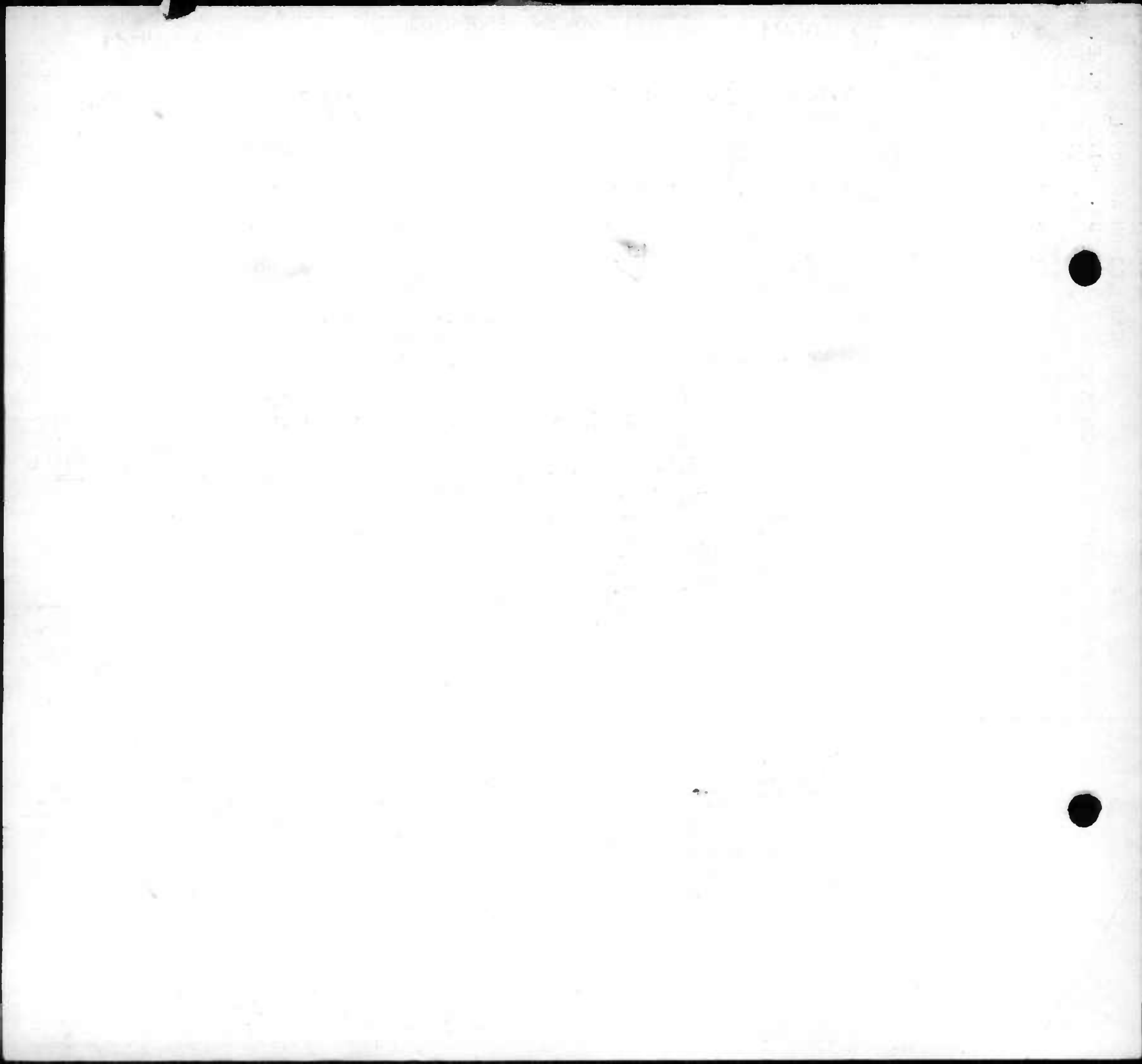
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ST

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00024		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00024	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JACK JOHNSON		2. DATE AND HOUR OF DEATH 1/1/72 7 <sup>20</sup> PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS Hopkins		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1519 Dallas st		6. SEX M		7. RACE N	
8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 4-16-23		10. AGE (In years last birthday) 48	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) Darlington, S. Carolina	
14. FATHER'S NAME ELLIOTT JOHNSON		15. MOTHER'S MAIDEN NAME LULA HARRISON		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. 248-14-5694		19. INFORMANT Mrs. Bertha L. Williams Mrs. Manzearter Williams 1519 N. Dallas St.	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C5 C6 fx (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 1 week		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 26		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 6		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1519 Dallas st		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 25 71 5:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Falling down steps		22. I certify that (1) (this hospital) attended the deceased from Dec 25 19 71 to 1/1 19 72 that (1) (we) lost saw the deceased alive on 1/1 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE G. GUCER	
23B. DATE SIGNED 1/2/72		23C. PHYSICIAN'S NAME (Type) G. GUCER		23D. ADDRESS JOHNS Hopkins.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-6-72		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR 735 Hartford Avenue Marshall W. Jones, Jr.		25D. ADDRESS		25E. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5164 1

72 00025

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00025

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John C. Schoeberlein (SCHOEBERLEIN)

2. DATE AND HOUR OF DEATH

1/2/72 9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4940 Eastern Avenue  
Baltimore, Maryland 21224

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE B. COUNTY

Md. 2605

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

422 Folcroft St.

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9/24/93

9. AGE (In years last birthday)

78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

REVERE PRESS & COPPER

11. BIRTHPLACE (State or foreign country)

Maryland, BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN G. SCHOEBERLEIN

14. MOTHER'S MAIDEN NAME

ELIZABETH FRIEDRICK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-03-3861-A

17. INFORMANT

4940 Eastern Avenue

BCH-RECORDS

Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary Edema

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Lung Cancer

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

6 months

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Congestive Heart failure

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from January 2, 1972 to Jan. 2, 1972 that (I) (we) last saw the deceased alive on Jan. 2, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Roland C. Einhorn, MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/2/72

23C. PHYSICIAN'S NAME (Type)

Roland C. Einhorn, MD

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1-6-72

24C. NAME OF CEMETERY OR CREMATORY

ST. STANISLAUS CEM.

24D. LOCATION

(City, town, or county) (State)

6515 BOSTON AVE. BALTO, 24, MD.

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

25B. NAME OF REGISTRAR

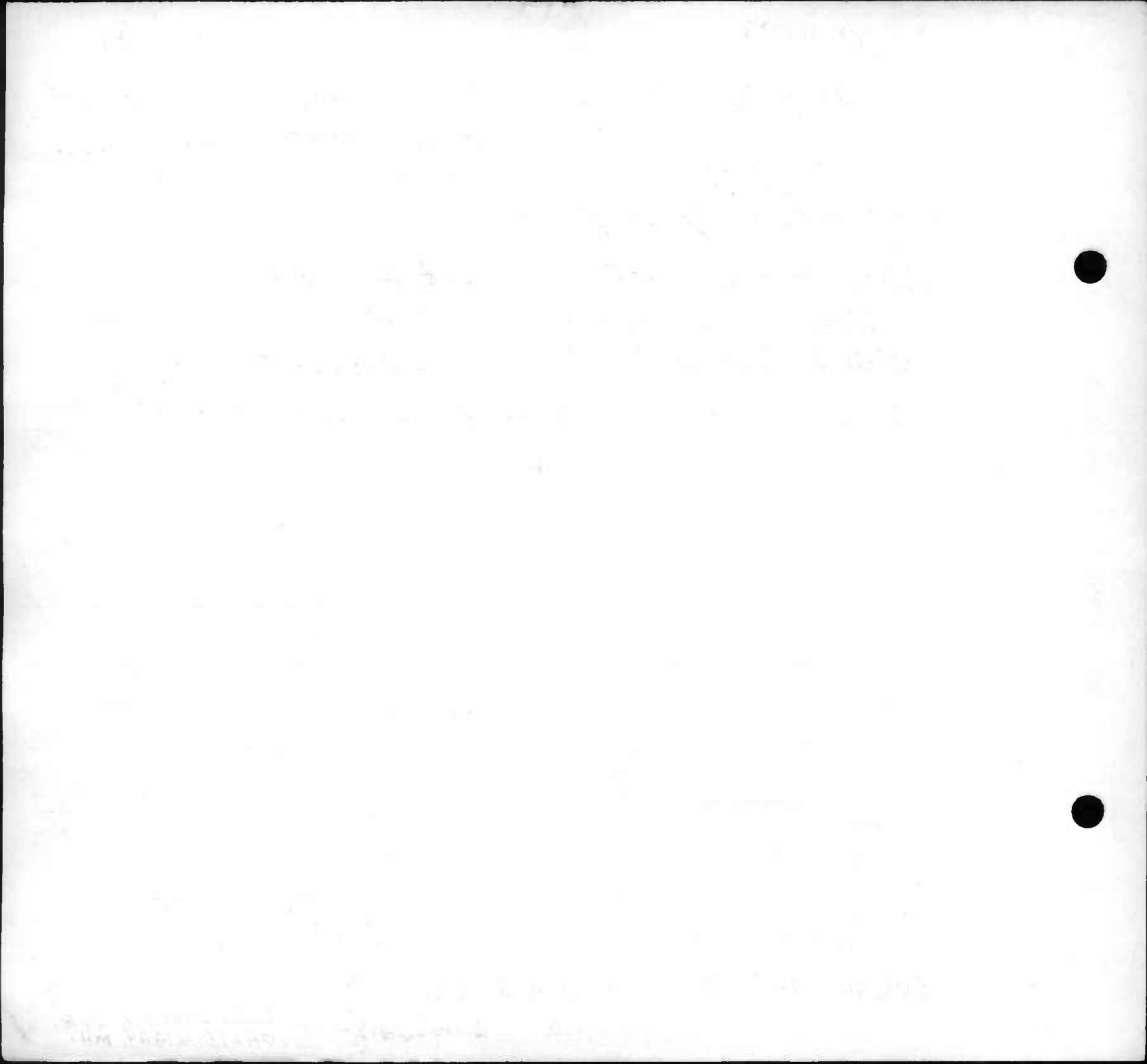
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Charles S. Guler

ADDRESS

6224 EASTERN AVE. BALTO, 21224, MD.





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72 00026

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00026

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Patrick Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 1 Year 72 Hour 12:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month 1 Day 1 Year 72 Hour 12:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 905	
9. DATE OF BIRTH 9-29-46		10. AGE (In years lost birthday) 25	
11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Motors		14B. KIND OF BUSINESS OR INDUSTRY General Motors	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO. 212-42-4013	
18. INFORMANT Patricia Johnson		ADDRESS 1400 Homestead St.	
19. CAUSE OF DEATH E-965 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME OF INJURY (APPROX.) Month 12 Day 31 Year 71 11:15 P.M.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2600 blk. Pierpont Ave. 2543	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner H. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner H. Spitz, M.D. DATE SIGNED 1-1-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-72	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR J. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

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72 00027

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00027

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>NORMAN HENRY JOHNSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2302 Koko Lane</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 2 1972 1:50 p</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>11-22-1908</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Eastern Shore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ed Johnson</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <b>Md.</b> B. COUNTY <b>1547</b>	
15. MOTHER'S MAIDEN NAME <b>Josephine Johnson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Yes</b>	
17. SOCIAL SECURITY NO. <b>220-09-6842</b>		18. INFORMANT <b>Norman L. Johnson</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fracture of neck</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22C. WHERE DID INJURY OCCUR? <b>2302 Koko Lane</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>1-1-72 ?</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Presumably fell in bathroom while inebriated</b> <b>Unknown - Found in bathtub</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> <b>Undetermined manner</b>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-3-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-6-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St.</b>	

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00028		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00028	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Williams, Joseph</u>		2. DATE AND HOUR OF DEATH <u>01-03-72 1:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (Type or Print) <u>BON SECOURS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2002</u>			
5. SEX <u>Male</u>		6. RACE <u>BLACK</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>08-22-97</u>		9. AGE (In years last birthday) <u>74</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel Williams</u>		14. MOTHER'S MAIDEN NAME <u>Emilia Williams</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07 7570</u>		17. INFORMANT <u>Heather Williams</u> ADDRESS <u>2110 W. Fairmont Ave.</u>	
18. <u>41231</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Subendocardial infarct</u> <u>days</u> DUE TO, OR AS A CONSEQUENCE OF: <u>anterior wall of left ventricle</u> (B) <u>arteriosclerotic heart disease</u> <u>years</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>01/01/72</u> 19 <u>72</u> to <u>01/03/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>01/03</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. DeBun</u> M.D.		23B. DATE SIGNED <u>1/3/72</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUELINO F. ALBUERNE, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-6-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cem.</u>	
24D. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>W. DeBun</u>		25D. ADDRESS <u>1704 - 1706 - 1708 - 1710 - 1712 - 1714 - 1716 - 1718 - 1720 - 1722 - 1724 - 1726 - 1728 - 1730 - 1732 - 1734 - 1736 - 1738 - 1740 - 1742 - 1744 - 1746 - 1748 - 1750 - 1752 - 1754 - 1756 - 1758 - 1760 - 1762 - 1764 - 1766 - 1768 - 1770 - 1772 - 1774 - 1776 - 1778 - 1780 - 1782 - 1784 - 1786 - 1788 - 1790 - 1792 - 1794 - 1796 - 1798 - 1800</u>			

1/21/72 - Correction form from funeral director.

*APC*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00029	
V-525 72 00029		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELIZABETH L. VANSANT		2. DATE AND HOUR OF DEATH 2 January 1972 9:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY USA		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital 35100 N. Broadway Baltimore MD		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5562 Gayland Rd.	
6. SEX Female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 28 October 1922	10. AGE (In years, last birthday) 49 yrs	11. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household		10B. KIND OF BUSINESS OR INDUSTRY —		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Arnold		14. MOTHER'S MAIDEN NAME Margaret Griffith		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215 146642		17. (INFORMANT Wilbur Vansant (Husband)		ADDRESS 5562, Gayland Rd.	
18. 22501		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cardio Respiratory failure		1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Brain tumor (Meningioma)		4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Brain Swelling		one month	
19A. DATE OF OPERATION 11-2-1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 19 October 1971 to 2nd January 1972 that (I) (we) last saw the deceased alive on 2 January 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Mehta		23B. DATE SIGNED 1/2/72		23C. PHYSICIAN'S NAME (Type) Dr. ASHWIN MEHTA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/6/72		24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Zuber, Jr.		25C. FUNERAL DIRECTOR Andrew C. INC 132 E. Lafayette St. Baltimore	





CORRECTIONS BY FUNERAL HOME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-250 72 00030		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00030	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) MEACHAM, DEACATOR.				2. DATE AND HOUR OF DEATH 1.1.72 10625A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE M.D. B. COUNTY BALTIMORE 5300			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHOREAPHOME & HOSP.				C. CITY OR TOWN DUNDALK		D. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 2422 Keyway. 21222			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7.21.09	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) computer specialization.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TENN.	
12. CITIZEN OF WHAT COUNTRY? AMER.				13. FATHER'S NAME JESSIE MEACHAM.			
14. MOTHER'S MAIDEN NAME MARY B LLEN RUPPIN.				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 213-104392				17. INFORMANT HOSPITAL			
18. 44191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 213-10-4392 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio respiratory failure. (B) DUE TO, OR AS A CONSEQUENCE OF: B. LEAFLET (C) Ruptured aortic aneurysm.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days. 5 days.	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 12.27.71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic aneurysm.		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12.21.71 to 12.1.72 that (I) (we) last saw the deceased alive on 12.1.72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A Mehta M.D. Dr. A. Mehta M.D. Dr. P. Herold M.D.				23B. DATE SIGNED 1/1/72		23C. PHYSICIAN'S NAME (Type) Dr. A. Mehta M.D. Dr. P. Herold M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/4/1972		24C. NAME of CEMETERY or CREMATORY DRUID RIDGE		24D. LOCATION (City, town, or county) (State) BALTO. Co. M.D.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR John E. Jones, Jr.		25C. FUNERAL DIRECTOR D. J. Doolittle, Dundalk, Md.		25D. ADDRESS	



## CERTIFICATE OF DEATH

REG. NO.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>C-615</b>		72 00031		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 00031</b>	
1. NAME OF DECEASED (Type or Print) <b>[REDACTED] (Carpino)</b>		2. DATE AND HOUR OF DEATH <b>Jan. 1, 1972 3:07 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		5. SEX <b>Male</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b>		6. ADDRESS OR LOCATION <b>Baltimore City Hospitals 1-212 4940 Eastern Avenue Baltimore, Maryland 21224</b>		C. CITY OR TOWN <b>DUNDALK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>1907 Madison Road 21222</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b>		8. DATE OF BIRTH <b>APR. 4, 1905</b>		9. AGE (In years last birthday) <b>66</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GENERAL WORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MISCELL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>PALMO (?)</b>		14. MOTHER'S MAIDEN NAME <b>(?)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>169-01-8378</b>		17. INFORMANT <b>BCH RECORDS:</b>		ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>		18. CAUSE OF DEATH <b>427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-vascular arrest 1 1/2 hours</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>X X X X X</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>X X X X X</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>findings same</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>Jan. 1, 1972</b> to <b>Jan. 1, 1972</b> that (1) (we) last saw the deceased alive on <b>Jan. 1, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>JAY E. MENITOVE M.D.</b>		23B. DATE SIGNED <b>Jan. 1, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>JAY E. MENITOVE M.D.</b>	
24A. BURIAL OR CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/4/1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>	
25B. NAME OF REGISTRAR <b>Robert E. [REDACTED]</b>		25C. FUNERAL DIRECTOR <b>NO [REDACTED]</b>		25D. [REDACTED]		25E. [REDACTED]		25F. [REDACTED]	

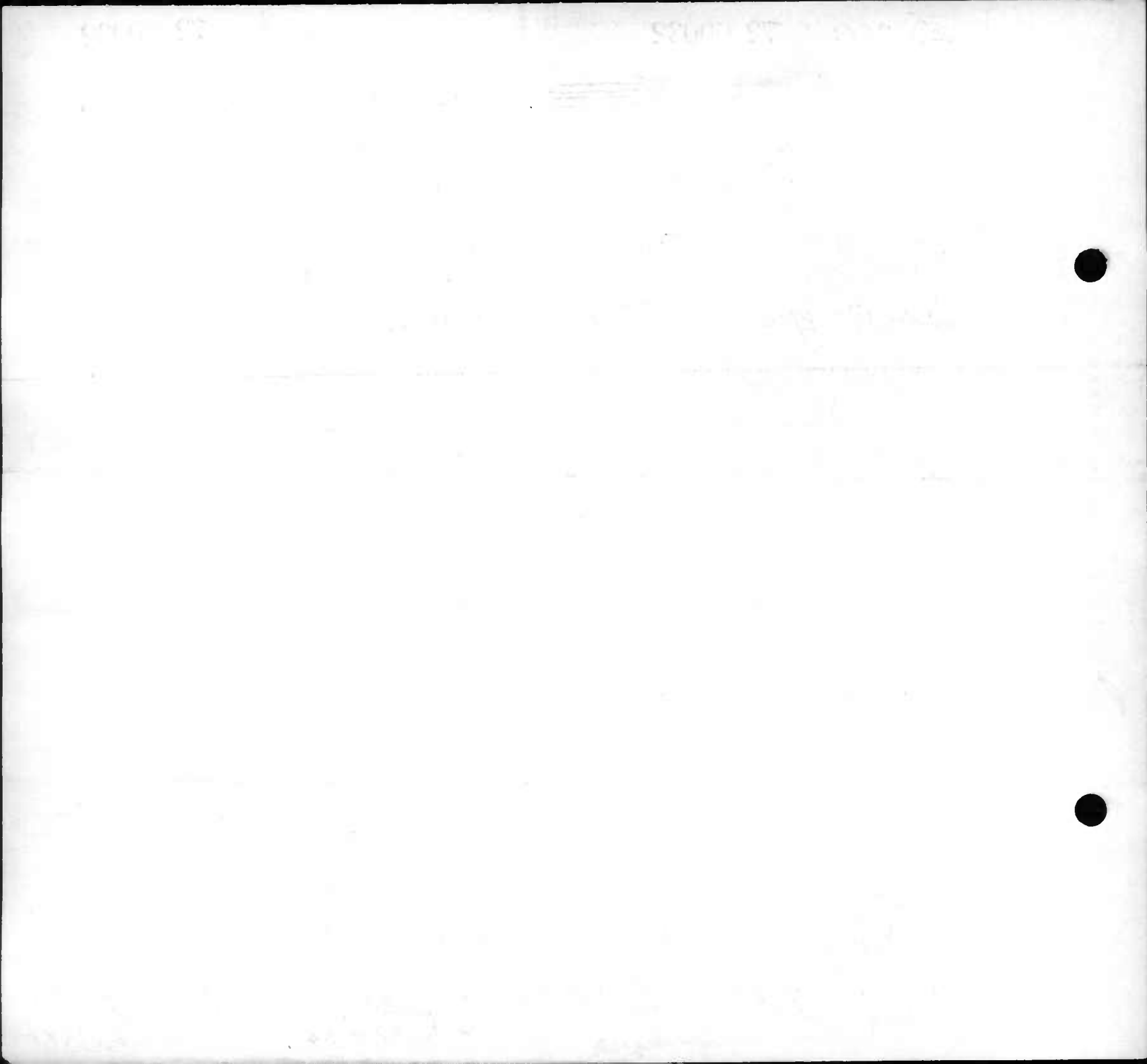
1-21-72 - Letter from Baltimore City Hospitals - (Mrs.) Helen Fisher  
Supervisor, Information Center

HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

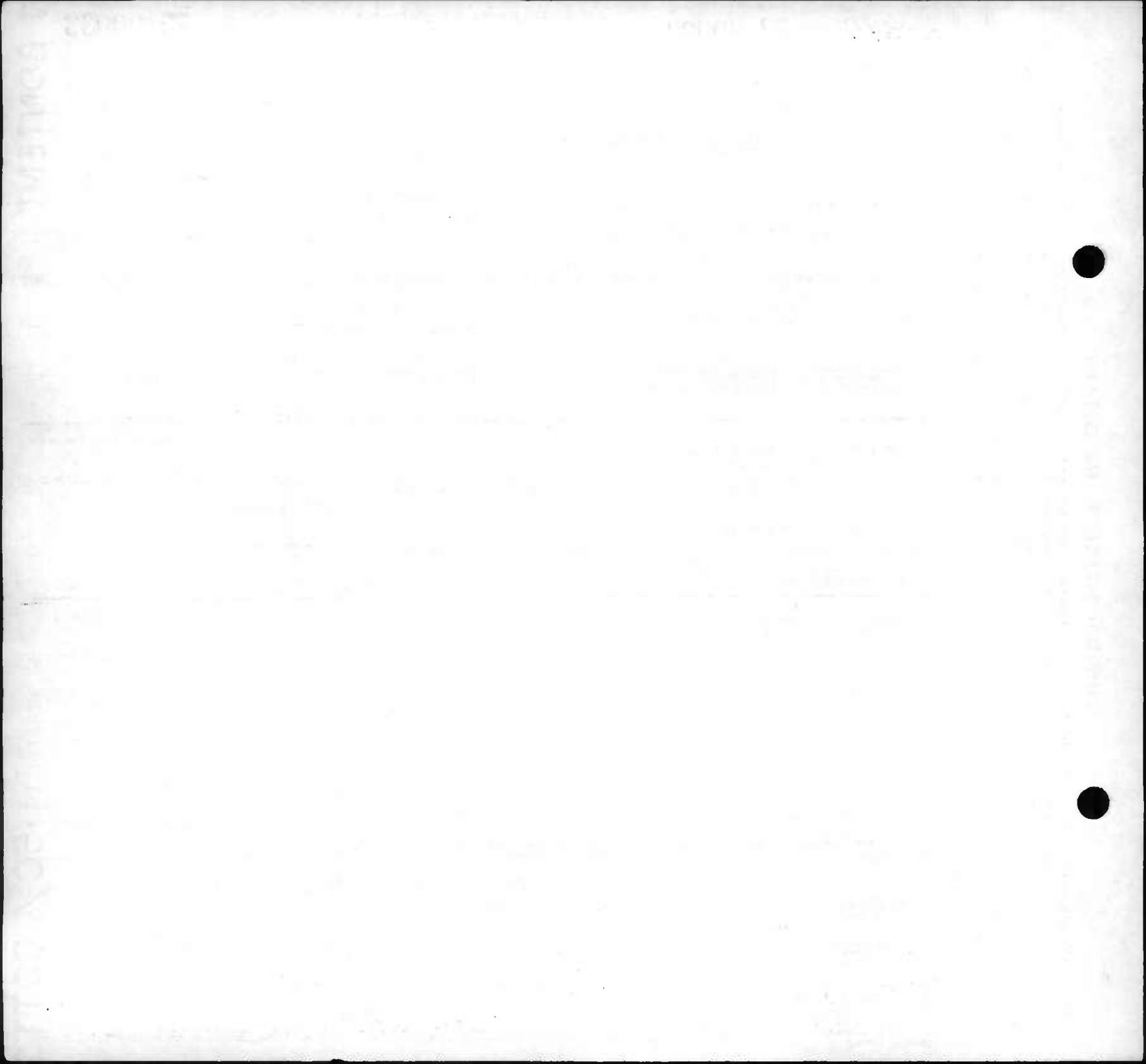
Z-260 72 00032		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		72 00032	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Zucker, <del>Isaac</del> Isaac</b>		2. DATE AND HOUR OF DEATH <b>0650 1/2/72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 Umb. of Md Hosp Cumberland &amp; Greene Sts</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>ALLEGANY</b> C. CITY OR TOWN <b>5100</b>			
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>145 Baltimore St</b>	
5. SEX <b>Male</b>	6. RACE <b>Caucase</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/11/22</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Abraham Zucker</b>		14. MOTHER'S MAIDEN NAME <b>Yetta Rabinowitz</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1942-45</b>		16. SOCIAL SECURITY NO. <b>3</b>		17. INFORMANT <b>Wife</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RENAL failure to uremia</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic adenocarcinoma of colon</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/5/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RENAL failure</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/5</b> 19 <b>71</b> to <b>1/2</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/1/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward B. Osteroff M.D.</b>		23B. DATE SIGNED <b>2 Jan 72</b>		23C. PHYSICIAN'S NAME (Type) <b>Edward B. Osteroff</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>East View Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Cumberland Allegany MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Charles E. Jones</b>	
25C. FUNERAL DIRECTOR <b>Charles E. Jones</b>		25D. ADDRESS <b>Cumt. Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-340 72 00033		BALTIMORE CITY HEALTH DEPARTMENT		72 00033	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>HEADLEY MRS. RUTH.</b>		2. DATE AND HOUR OF DEATH <b>11. 72 3.05A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3037 LIBERTY PARKWAY</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7. 9. 03</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>KANSAS</b>	
13. FATHER'S NAME <b>JOHN TODD</b>		14. MOTHER'S MAIDEN NAME <b>MARY NICHOLAS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214 18 0 022</b>		17. INFORMANT <b>Herold Headley, 3037 Liberty Parkway</b> ADDRESS <b>3037 LIBERTY PARKWAY</b>	
18. <b>174X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio respiratory failure</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic Carcinoma of breast with mets.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>7 months</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-20-1971</b> to <b>1.1.1972</b> that (I) (we) last saw the deceased alive on <b>12-31-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>AMehl</b> <b>MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. A. MEHL</b>		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN 72</b>		24C. NAME of CEMETERY or CREMATORY <b>Howard Co, Md</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Charles F. Taylor, Jr.</b>		ADDRESS <b>21222</b>	

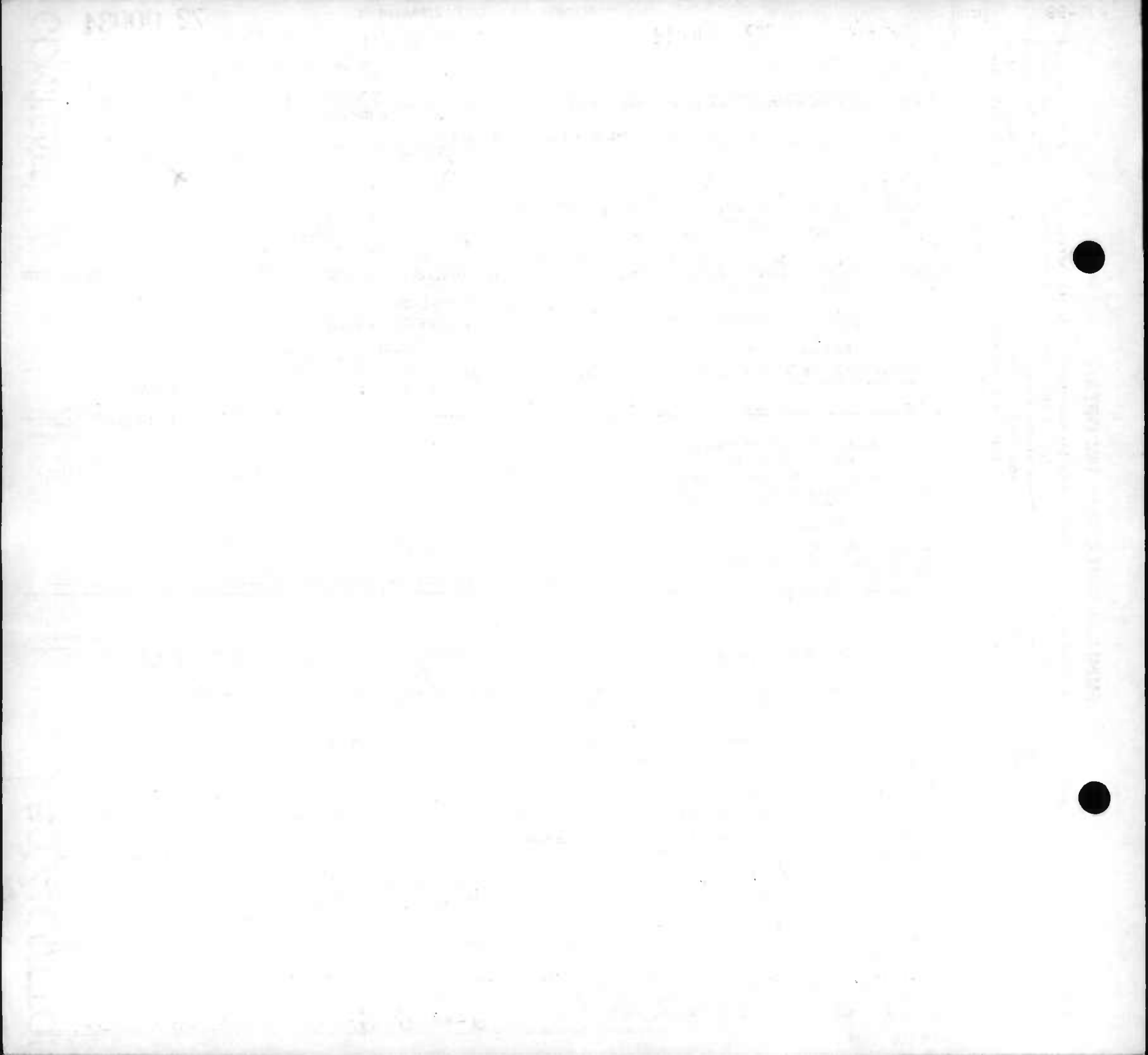




## FUNERAL DIRECTOR: IMPORTANT

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W-234		72 00034		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00034	
BIRTH NO.				72 00034			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HOWARD J. WASTLER				January 1st 1972 4:08 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals				MD			
4940 Eastern Avenue, Baltimore, Maryland				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER			
				356 Gusman St. 21224			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 1 Yr. Days	12. Under 24 Hrs. Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-24-1915	56			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Clerk				Maryland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
U.S. Postal Service				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Russell WASTLER				Lulu Kaise			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> WW II				216-01-7847			
17. INFORMANT				ADDRESS			
BCH RECORDS:				4940 Eastern Avenue			
				Baltimore, Maryland 21224			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2 hours			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Myocardial Infarction			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Previous myocardial infarction			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from Jan 1st 1972 to Jan 1st 1972 that (2) (we) last saw the deceased alive on Jan 1st 1972 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. MAKARY M.D.				January 1st 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A. MAKARY M.D.				Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Jan 4th		Bel Air Memorial Gardens		Bel Air, MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 4 1972		Robert E. Taylor M.D.		Gloria General Home, Baltimore		Baltimore	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00035	
CERTIFICATE OF DEATH					
BIRTH NO. T-460		72 00035			
1. NAME OF DECEASED (Type or Print) WILLIAM J. TAYLOR, Jr.		2. DATE AND HOUR OF DEATH Jan. 2 - 1972 9:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1307			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
44		E. STREET AND NUMBER 620 W. 40TH ST. 2121			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-1891	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Plant Manager Continental Can Co.		10B. KIND OF BUSINESS OR INDUSTRY Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William J. Taylor		14. MOTHER'S MAIDEN NAME Isabel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. William J. Taylor	
18. 42701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH INTRACTABLE CARDIAC ARHYTHMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE PULM. EDEMA (B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC HEART FAILURE (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY <input checked="" type="checkbox"/> NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Jan. 2 19 72 to Jan. 2 19 72 that (I) (we) last saw the deceased alive on 1-2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Mikos, M.D.				23B. DATE SIGNED 1-2-72	
23C. PHYSICIAN'S NAME (Type) J. P. MIKOS, M.D.				23D. ADDRESS VMA	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972			
25B. NAME OF REGISTRAR J. P. Mikos, M.D.		25C. FUNERAL DIRECTOR J. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			

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150000 150000

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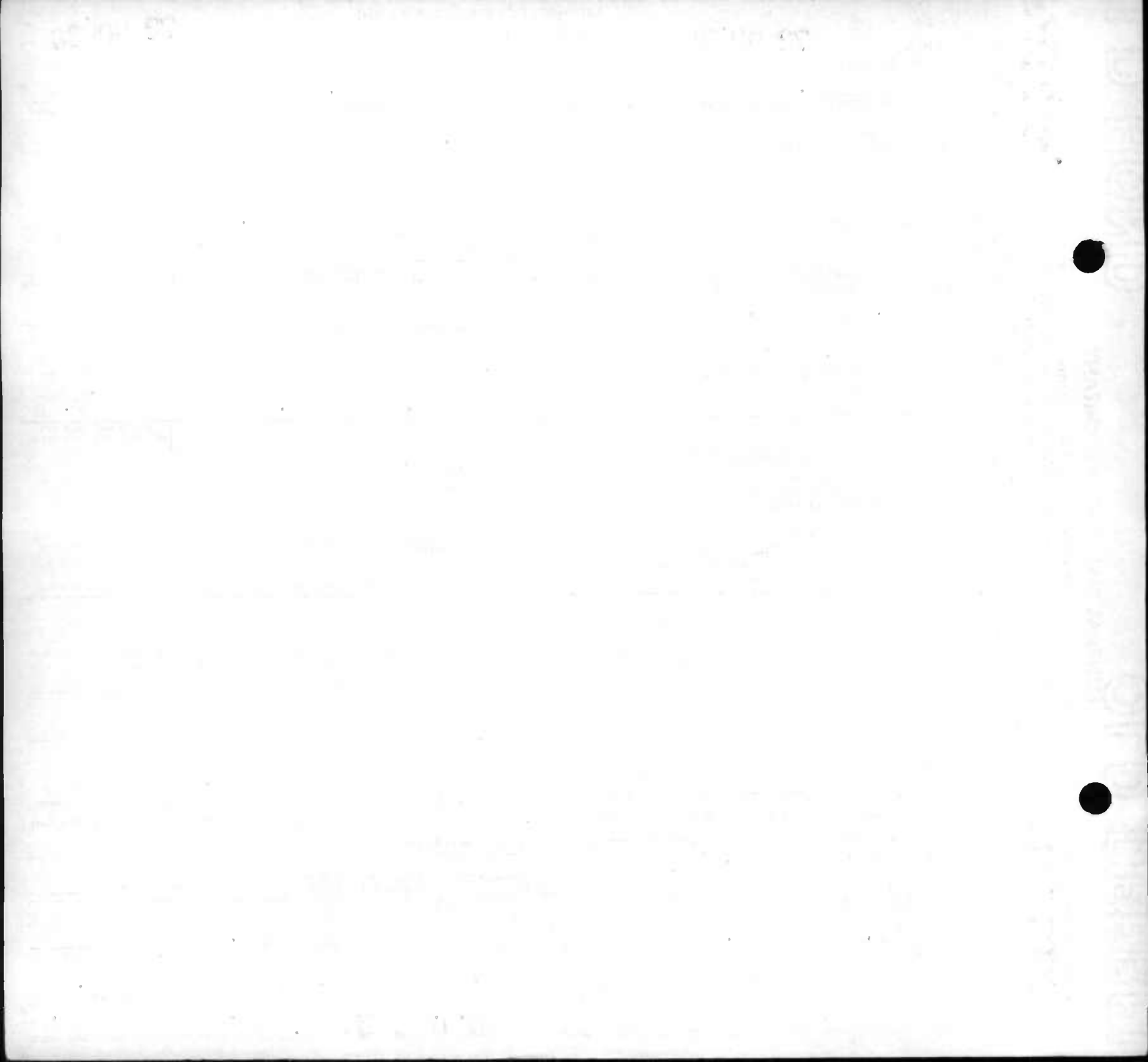
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00036</span>	
H-200 72 00036				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="float: right;">J. Irvin Heise</span>			2. DATE AND HOUR OF DEATH <span style="float: right;">Jan. 1, 1972 5 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span>  <span style="font-size: 2em;">44</span> Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">2759</span>		
			C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="float: right;">4409 Marble Hall Rd. 21218</span>		
5. SEX <span style="float: right;">M</span>	6. RACE <span style="float: right;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">1-27-94</span>	9. AGE (In years last birthday) <span style="float: right;">77</span>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Balto. G &amp; Elec. Supervisor</span>			11. BIRTHPLACE (State or foreign country) <span style="float: right;">Baltimore, Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">USA</span>
13. FATHER'S NAME <span style="float: right;">John D. Heise</span>			14. MOTHER'S MAIDEN NAME <span style="float: right;">Mary Dauterich</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">yes WW 1</span>			16. SOCIAL SECURITY NO. <span style="float: right;">212-05-6537</span>		17. INFORMANT <span style="float: right;">John I. Heise, Jr.</span> ADDRESS <span style="float: right;">Bethesda, Md. 20034 6808 Newbold Dr.</span>
18. <span style="font-size: 1.5em;">410.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">Coronary Occlusion</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <span style="font-size: 1.5em;">O</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">no</span>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Jan 1971</span> to <span style="float: right;">Jan 1 1972</span> and that (I) (we) last saw the deceased alive on <span style="float: right;">Dec 16 1971</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Wm. H. Fusting</span>			23B. DATE SIGNED <span style="float: right;">1-3-72</span>		23C. PHYSICIAN'S NAME (Type) <span style="float: right;">Dr. William H. Fusting</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>			24B. DATE <span style="float: right;">1-4-72</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Woodlawn Cemetery</span>
24D. LOCATION <span style="float: right;">Baltimore County, Md.</span>			25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JAN 4 1972</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Jenkins</span>			25C. FUNERAL DIRECTOR <span style="float: right;">H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</span>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-635 72 00037				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00037	
1. NAME OF DECEASED (Type or Print) <b>GORDON, HOWARD J.</b>		2. DATE AND HOUR OF DEATH <b>11/1/72 7<sup>30</sup> A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTO.</b> B. COUNTY <b>21206</b>			
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/1/03</b>	
9. AGE (In years last birthday) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CHIEF</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LEONARD GORDON</b>				14. MOTHER'S MAIDEN NAME <b>LAURA ? MANTLER</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>214-20-8380</b>		17. INFORMANT <b>ETHEL GORDON, 4217 Seidel Ave. 21206</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>POSS. CARDIAC ARREST FOR PULMONARY</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>min.</b>			
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause, stating the UNDERLYING CONDITION last.) <b>LLL pneumonia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>STATUS POST C.V.A.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>		21C. WHERE DID INJURY OCCUR? <b>4217 Seidel Ave. Balto. Md. 21206</b>		21D. TIME OF INJURY (APPROX.) <b>12-27-71</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>SLIPPED ON FLOOR</b>		21G. DATE OF OPERATION <b>6</b>		21H. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>6</b>	
21I. DATE OF OPERATION <b>6</b>		21J. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>6</b>		21K. AUTOPSY (Yes or No) <b>0</b>		21L. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>26 42</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>71</b> to <b>1/1</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1-1-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>A.E. WALSH MD</b>				23D. ADDRESS <b>222 St. Paul</b>		23E. DATE SIGNED <b>1-1-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN 4 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>STANTON GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Valley, MD.</b>		25C. FUNERAL DIRECTOR <b>Edwin J. General, Balto., MD. 21204</b>		25D. ADDRESS <b>Edwin J. General, Balto., MD. 21204</b>	

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

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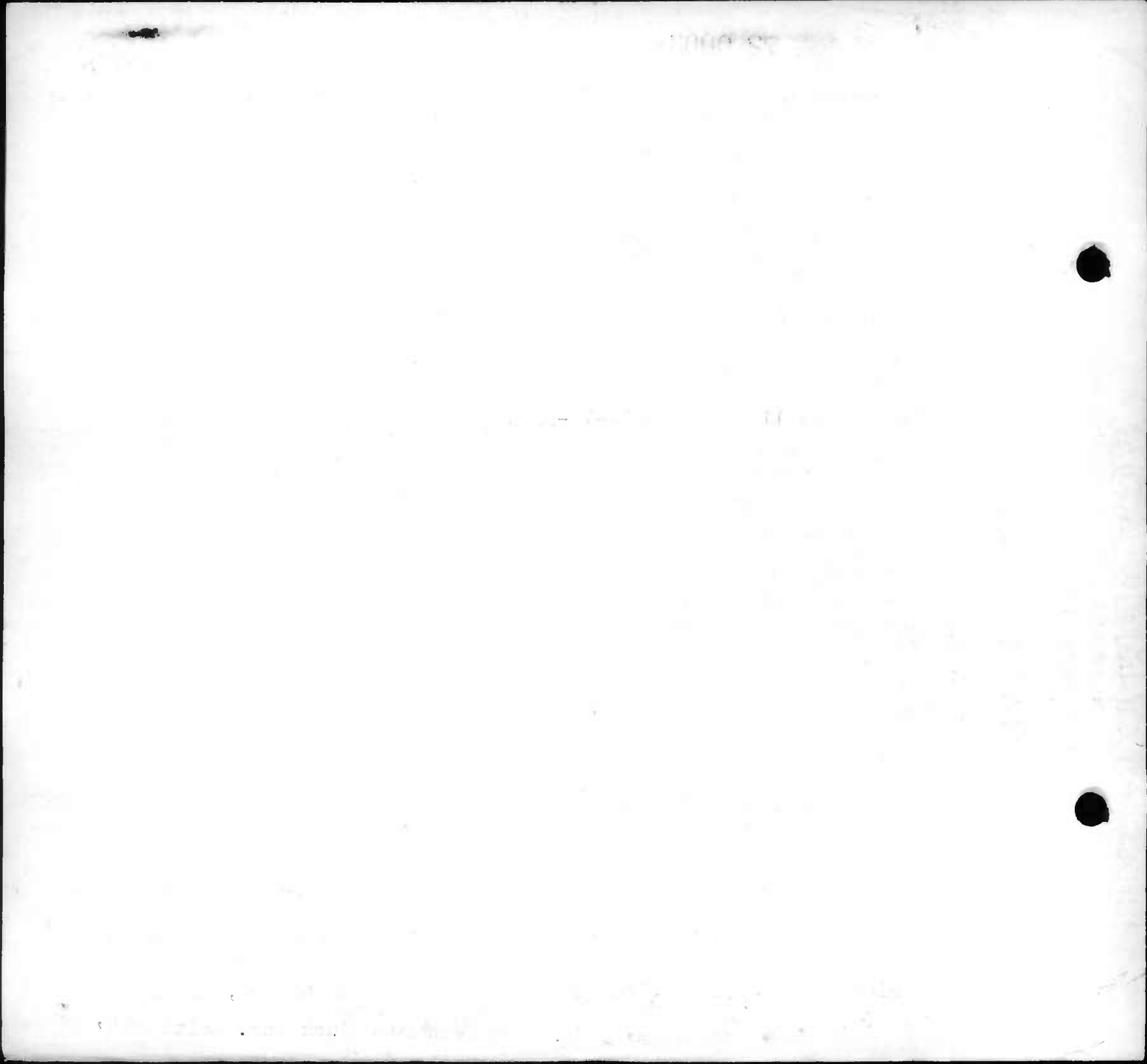
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00038	
K-656 72 52-00038				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANTHONY J. KRAMER</b>		2. DATE AND HOUR OF DEATH <b>1-2-72 5:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>IND</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>North Charles Gen. Hosp</b> <b>NORTH CHARLES GEN. HOSPITAL</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>5519 Summerfield Ave</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-21-21</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Businessman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MTA</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>August Kramer</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth ZINKARD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>212-18-3353</b>		17. INFORMANT <b>Medical Records</b> ADDRESS	
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>CA COLON E WIDESPREAD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>CA COLON E WIDESPREAD</b> CAUSE OF DEATH <b>CA COLON E WIDESPREAD</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTASIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2-1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-2-72</b> to <b>1-2-72</b> that (I) (we) last saw the deceased alive on <b>1-2-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jacinto V. de Borda, M.D.</b>				23B. DATE SIGNED <b>1-2-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jacinto V. DE BORDA, M.D.</b>				23D. ADDRESS <b>North Charles Gen. Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Md</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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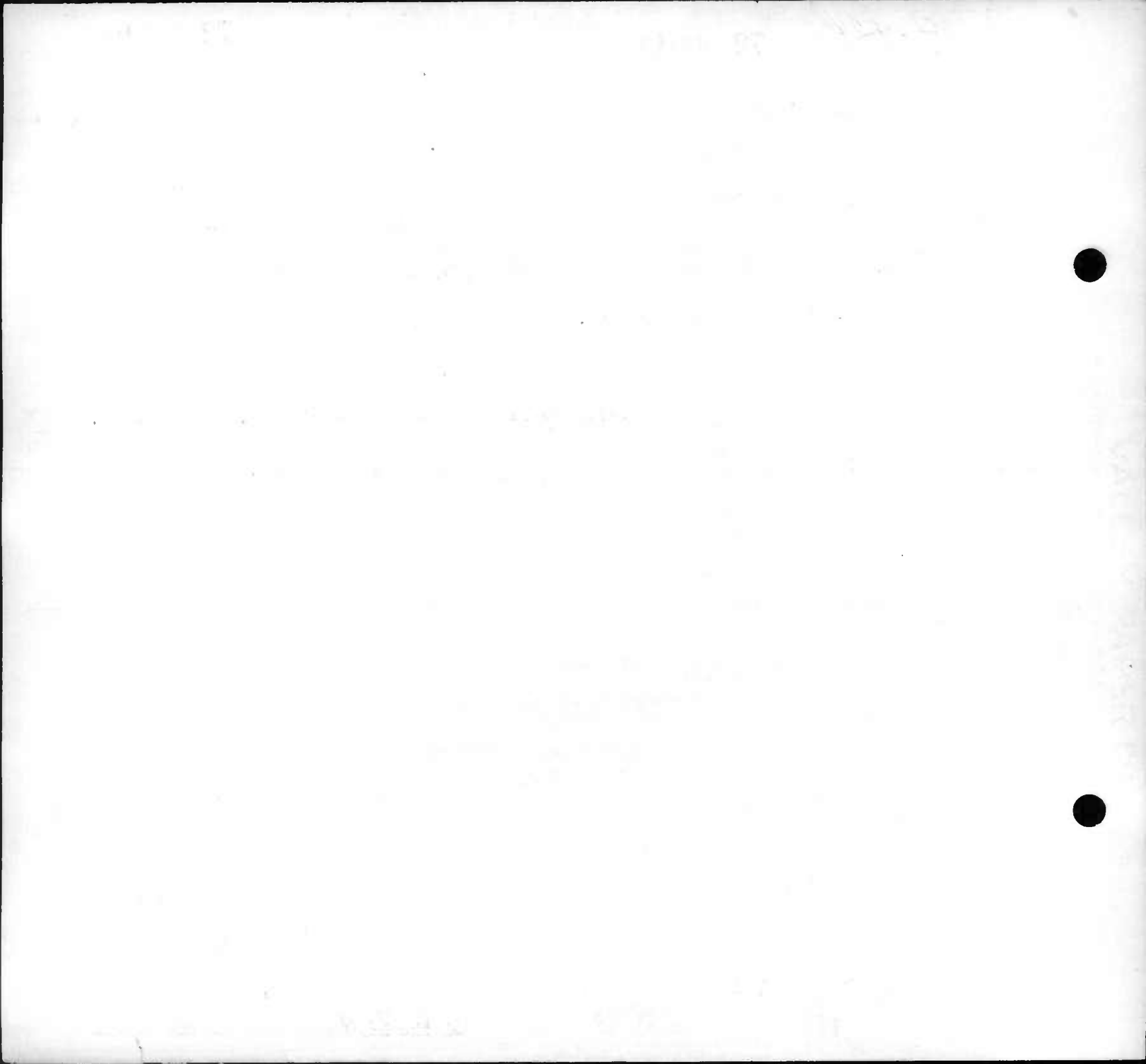
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00040		72 00040	
BIRTH NO.		7-424		72 00040	
1. NAME OF DECEASED (Type or Print)		FLDEGER, JOSEPH		2. DATE AND HOUR OF DEATH 1-1-1972 10:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md.		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
LUTHERAN HOSPITAL OF MD.		E. STREET AND NUMBER 2647 Miles Avenue		21211	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/17/02	9. AGE (In years last birthday) 69 yrs	10. Under 1 Yr. Months Days 10 1 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Cook		10B. KIND OF BUSINESS OR INDUSTRY Miller Bros.		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME late Marie		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-7022		17. INFORMANT Fredinand Fiastro 3 E. Lexington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gram +ve Sepsicemia Bronchial Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12-17-71 to 1-1-72 that (1) (we) last saw the deceased alive on 1-1-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE H. J. Kain MD DEGREE		23B. DATE SIGNED 1-1-1972	
23C. PHYSICIAN'S NAME (Type) H. J. Kain MD DEGREE		23D. ADDRESS LUTHERAN HOSPITAL OF MD. 730 N. BROAD ST. BALTIMORE, MD 21201		23E. ADDRESS 730 N. BROAD ST. BALTIMORE, MD 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/5/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 5 1972		24F. NAME OF REGISTRAR Edmondson Avenue 21228	
24G. DATE REC'D BY HEALTH DEPT. JAN 5 1972		24H. NAME OF REGISTRAR Edmondson Avenue 21228		24I. FUNERAL DIRECTOR Edmondson Avenue 21228	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-600 72 00041</span> <span>CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>72 00041</u>	
BIRTH NO. <u>B-600 72 00041</u>		1. NAME OF DECEASED (Type or Print) <u>IRENE A. BAUER</u>	
2. DATE AND HOUR OF DEATH <u>1-3-72</u> <u>15 20 P.</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Howard</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home Hospital</u> <u>1001 Broadway St.</u> <u>Baltimore MD 21231</u>	
6. DATE OF BIRTH <u>03-08-91</u>		7. AGE (In years last birthday) <u>80</u>	
8. SEX <u>Female</u> 9. RACE <u>White</u> 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Not available to me</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>		13. FATHER'S NAME <u>Walter Smith</u> <u>Not available to me</u>	
14. MOTHER'S MAIDEN NAME <u>Mary N. Pfeiffer</u> <u>Not available to me</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>A. Fouad Mous</u> ADDRESS <u>Church Home Hosp.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> <u>A.S.C.V.D.</u> <u>arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>many years</u> <u>many years</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Primary Trunk Infection</u> <u>Septicemia</u> <u>Diabetes Mellitus</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Two weeks</u> <u>many years</u>	
20. DATE OF OPERATION <u>none</u>		21. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>	
22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>none</u>		23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	
24. TIME OF INJURY (Month (Day) (Year) (Hour)) <u>none</u>		25. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>none</u>	
26. HOW DID INJURY OCCUR? <u>none</u>		27. I certify that (I) (this hospital) attended the deceased from <u>12-25-1971</u> to <u>1-3-72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-3-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.	
28. SIGNATURE <u>Germa P. Indolos M.D.</u>		29. DATE SIGNED <u>1/3/72</u>	
30. PHYSICIAN'S NAME (Type) <u>GERMA P. INDOLOS M.D.</u>		31. ADDRESS <u>Church Home Hospital</u>	
32. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE <u>1/7/72</u>	
34. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		35. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
36. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		37. NAME OF REGISTRAR <u>Robert E. J. ...</u>	
38. FUNERAL DIRECTOR <u>Mc Gully Funeral Homes</u>		39. ADDRESS <u>130 E. Fort Avenue</u>	

1900

1900

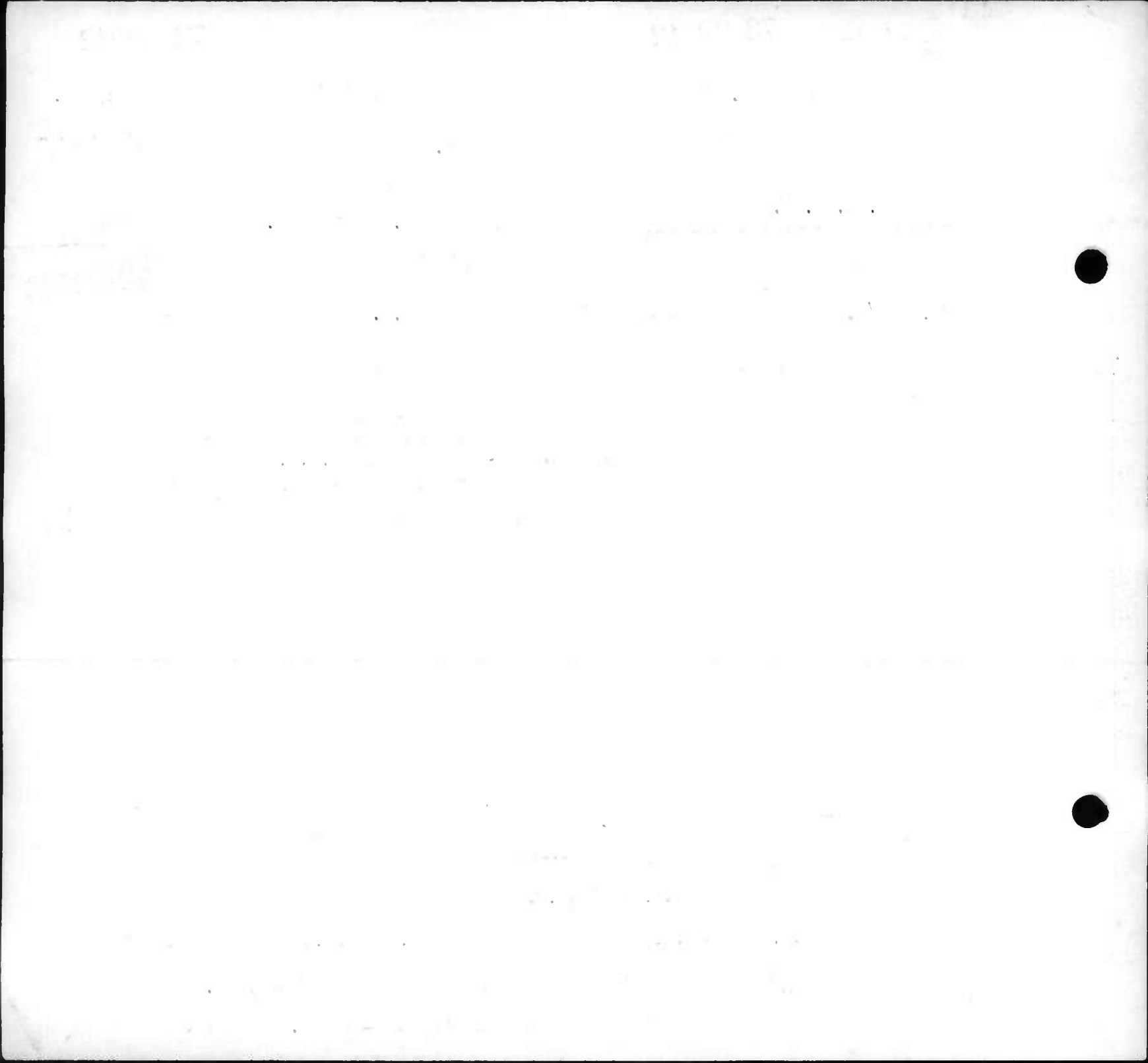




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-162		72 00042		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00042	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harry S. Shivers</i>				2. DATE AND HOUR OF DEATH <i>1/2/72</i> <i>7:50 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 S. B. G. H.</i>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2404</i>			
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <i>6/12/91</i>		9. AGE (In years last birthday) <i>80</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ir. Dept.</i>						10B. KIND OF BUSINESS OR INDUSTRY <i>News - American</i>		11. BIRTHPLACE (State or foreign country) <i>N.J.</i>	
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <i>Unknown</i>						14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Family - Same</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH <i>Acute myocardial infarction-sudden. Arteriosclerotic C.V.D., class</i> (A) IMMEDIATE CAUSE II-III, with history of angina pectoris- duration <i>12 yrs. +</i> Diabetes mellitus- duration <i>5 yrs. +</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1960</i> to <i>present time</i> , 19 <i>60</i> that (I) (we) lost saw the deceased alive on <i>Dec. 27</i> , 19 <i>71</i> and that <i>in</i> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>R.V. Rangle</i>						23B. DATE SIGNED <i>1/4/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>R.V. Rangle, M.D.</i>						23D. ADDRESS <i>2938 St. Paul St., Baltimore, Md. 21218</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/5/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1972</i>		25B. NAME OF REGISTRAR <i>2000</i>		25C. FUNERAL DIRECTOR <i>McGully</i>		ADDRESS <i>130 E. Fort Ave.</i>			



W-325

72 00043

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00043

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Loring Watkins				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 1 72 7:35 A.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 7:35 A.M.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Aug. 8 1947				10. AGE (in years lost birthday) 24		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Wm. R. Watkins			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker IGA Food Store				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Anna Mae Smith				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1967-1969			
17. SOCIAL SECURITY NO. 215-44-3796				18. INFORMANT ADDRESS Wm. R. Watkins Rt. 2 Box 32 Waldorf, Md.			
19. CAUSE OF DEATH E815.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Edgewater, Anne Arundel Co., Md.				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1 1 72 A.m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Driver of auto into fixed object			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Jan. 5, 1972			
24C. NAME OF CEMETERY or CREMATORY Trinity Mem. Gardens				24D. LOCATION (City, town, or county) (State) Waldorf Charles Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972				25B. NAME OF REGISTRAR Robert E. [illegible]			
25C. FUNERAL DIRECTOR				25D. ADDRESS Huntt F. H. Waldorf, Md.			

ST 0000

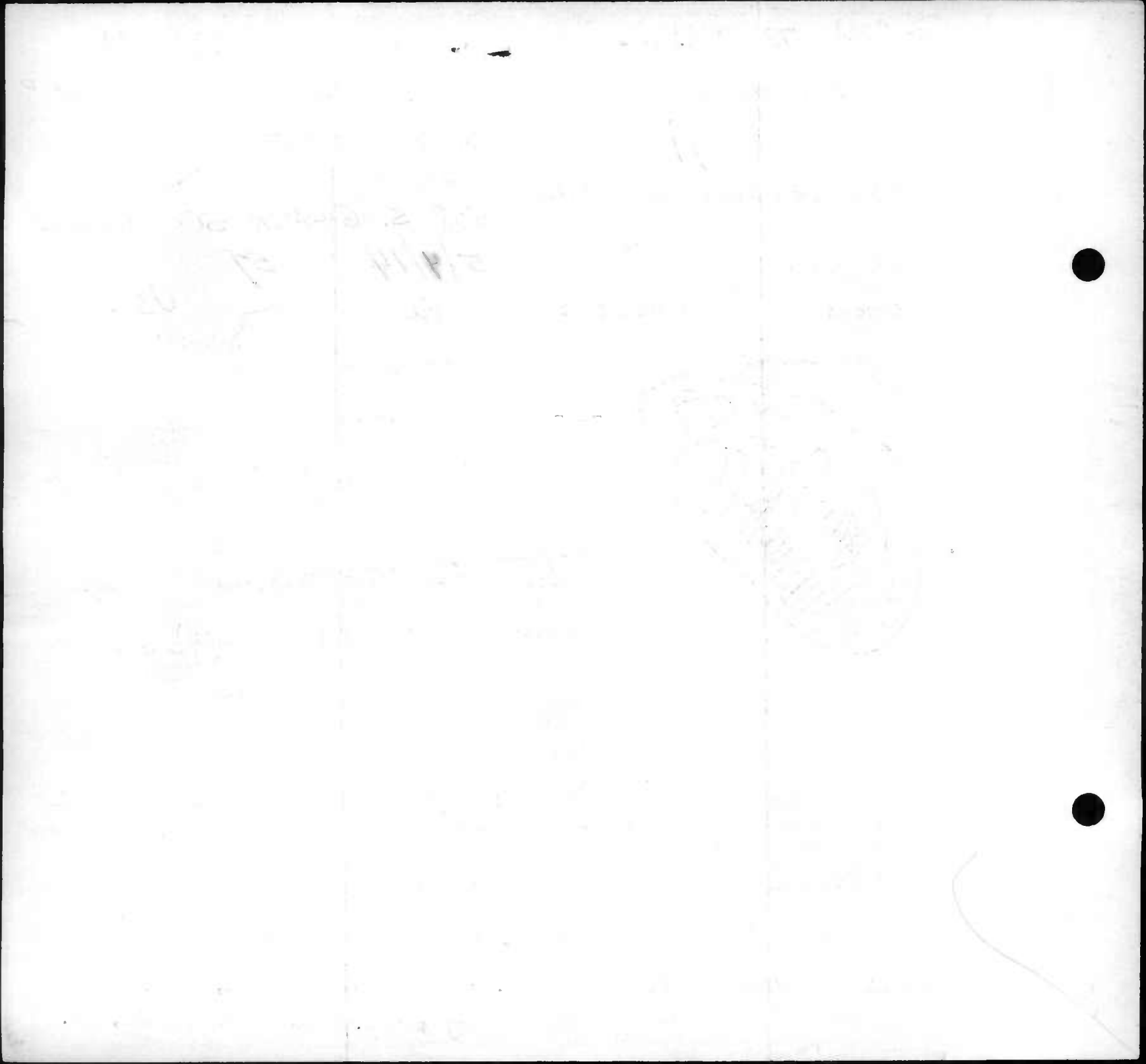
ST 0000



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-200 72 00044		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00044	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MAXINE SKAGGS</b>		2. DATE AND HOUR OF DEATH <b>1/2/72 7:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BON SECOURS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALT.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		C. CITY OR TOWN <b>BALT.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <b>508 S. GILMOR ST. BAL-23</b>			
5. SEX <b>Female</b>	6. RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/9/14</b>	9. AGE (in years last birthday) <b>57</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Modger Skaggs</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Piater</b>		15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>Yes, no or unknown</b>			
16. SOCIAL SECURITY NO. <b>212-10-6966</b>		17. INFORMANT <b>Chart</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Overdosage of barbiturate</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Aspiration pneumonia</b>		<b>days</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic alcoholism (clinical)</b>				<b>- years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21C. WHERE DID INJURY OCCUR? <b>508 S. Gilmore St 19-03</b>			
21D. TIME OF INJURY (APPROX.) <b>12/30/71</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>took overdose of sleeping pills</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>71</b> to <b>1-2</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. Burnie</b>		23B. DATE SIGNED <b>1/3/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Monaghan P. BURBANK</b>		23D. ADDRESS <b>7935 Pipers Point Glen Burnie Md 21061</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/5/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Raymond C. Fink</b>	
				ADDRESS <b>Glen Burnie, Md.</b>	



R-263 72 00045

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00045

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lee Norman Richardson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 1 72 12:22 P.M.	
4. PLACE IN BALTIMORE, MARYLAND WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 240 S. Spring Court		3. DATE PRONOUNCED DEAD Month Day Year 1 1 72 12:22 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 909	
9. DATE OF BIRTH 11-21-1951		10. AGE (in years last birthday) 20	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lee Colloway		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Hazel Mae Richardson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 212-60-2700		18. INFORMANT Mrs. Bertha B. Bryon 3809 Fairview Ave.	
19. E 965X1 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Found: 240 S. Spring Court		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Unknown	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot in chest by unknown assailant	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-2-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-1972	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR 1735 Harford Avenue Marshall W. Jones, Jr.		21213	

N 875.1 000011





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

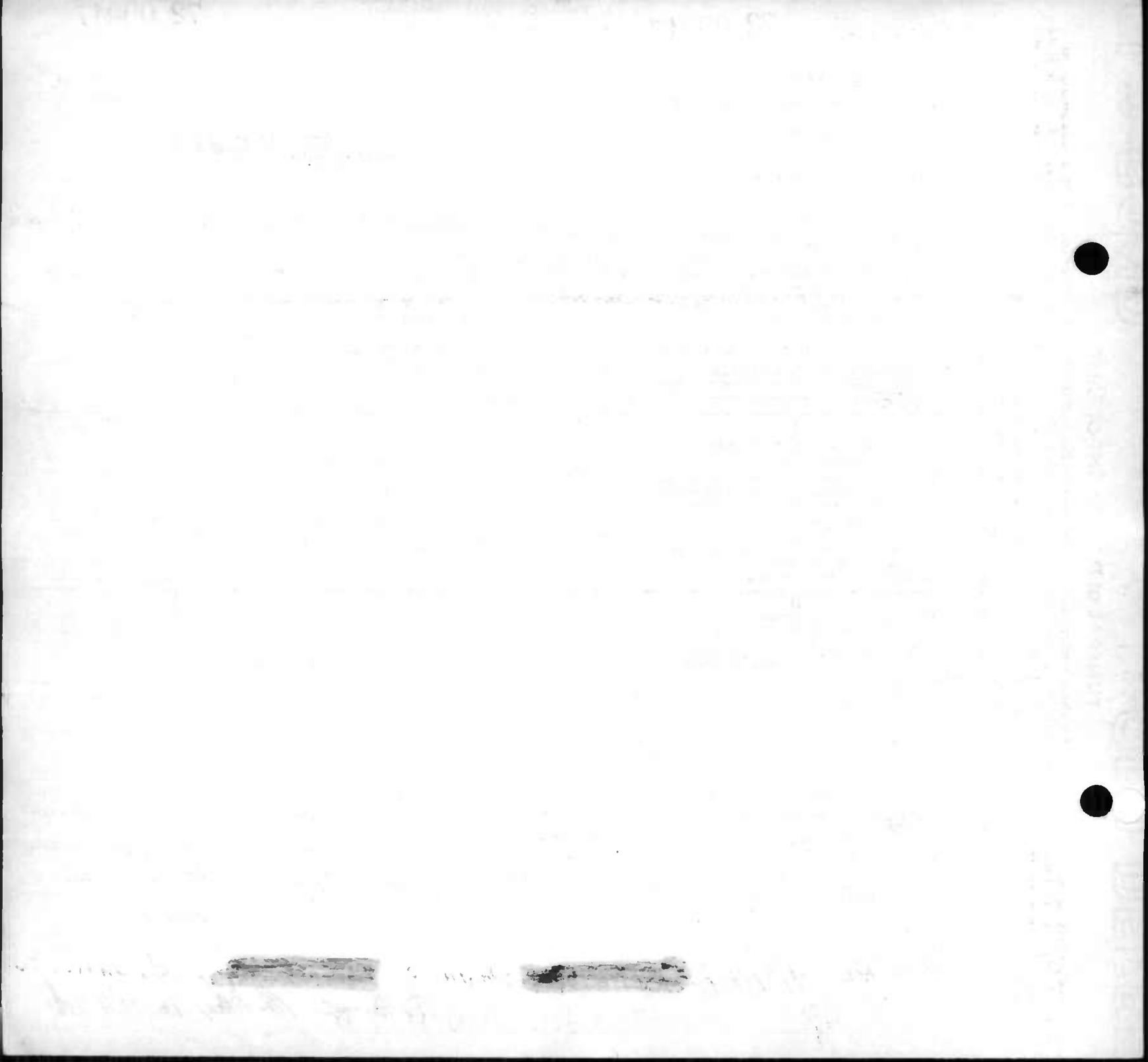
<p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">V-420</span> <span style="font-size: 1.5em;">72 00046</span></p> <p style="text-align: right;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;"><b>REG. NO.</b> <span style="font-size: 1.5em;">72 00046</span></p>			
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">VALLEJO, LUIS</span></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">1-1-72</span> <span style="font-size: 1.2em;">18:00 A.M.</span></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>   <div style="display: flex; justify-content: space-between;"> <div> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.2em;">35</span> <span style="font-size: 1.2em;">CHURCH HOME + HOSPITAL</span></p> </div> <div> <p><b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b></p> </div> </div> </p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)  <div style="display: flex; justify-content: space-between;"> <div> <p><b>A. STATE</b> <span style="font-size: 1.2em;">MARYLAND</span></p> </div> <div> <p><b>B. COUNTY</b> <span style="font-size: 1.2em;">2788</span></p> </div> </div> </p>	
<p><b>5. SEX</b> <span style="font-size: 1.2em;">Male</span> <b>6. RACE</b> <span style="font-size: 1.2em;">White</span></p>		<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>  <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">10-19-16</span></p>		<p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">55</span></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">mechanic</span></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Shipbuilding</span></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">ECUADOR</span></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p>	
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">EMILIO VALLEJO</span></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ZOALA ERRAQUEZ</span></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <span style="font-size: 1.2em;">no</span></p>		<p><b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">212-46-5708</span></p>	
<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Maria Vallejo</span></p>		<p><b>ADDRESS</b> <span style="font-size: 1.2em;">5425 Jonquil Ave</span></p>	
<p><b>18. CAUSE OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <div> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p><b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cerebral Anoxia</span></p> <p><b>(B) ACUTE MYOCARDIAL DYSFUNCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Acute Myocardial Dysfunction</span></p> <p><b>(C)</b></p> </div> <div> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">few min.</span> <span style="font-size: 1.2em;">few hrs.</span> <span style="font-size: 1.2em;">days</span></p> </div> </div> </p>			
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">1-1-72</span> <b>19</b> <span style="font-size: 1.2em;">72</span> <b>to</b> <span style="font-size: 1.2em;">1-1-72</span> <b>19</b> <span style="font-size: 1.2em;">72</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">1-1-72</span> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Ma. Elena V. Mangay</span> <span style="font-size: 1.2em;">MD</span></p>		<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1-1-72</span></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">MA. ELENA V. MANGAY</span></p>		<p><b>23D. ADDRESS</b> <span style="font-size: 1.2em;">160 N Broadway, Baltimore, Maryland</span></p>	
<p><b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Temporary Entombment</span></p>		<p><b>24B. DATE</b> <span style="font-size: 1.2em;">1-5-71</span></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Woodlawn Mausoleum</span></p>		<p><b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">BALTO, MARYLAND</span></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 5 1972</span></p>		<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. [unclear]</span></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Arlene [unclear]</span></p>		<p><b>ADDRESS</b> <span style="font-size: 1.2em;">4600 Liberty Heights Avenue</span></p>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00047</span>	
M-625 72 00047				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">1</span>		1. NAME OF DECEASED (Type or Print) <b>LEONARD C. MORRISON</b>		2. DATE AND HOUR OF DEATH <b>1-2-72 10:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>35</b>		C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? <b>BALTIMORE</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETD. POLICEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFR.</b>		8. DATE OF BIRTH <b>2-1-05</b>	
13. FATHER'S NAME <b>WILLIAM MORRISON</b>		14. MOTHER'S MAIDEN NAME <b>EMMA HASTINGS</b>		9. AGE (In years last birthday) <b>66</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-4018</b>		11. BIRTHPLACE (State or foreign country) <b>W. V. A.</b>	
17. INFORMANT <b>LEONARD R. MORRISON - SAME</b>		ADDRESS			
18. <b>412.4 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> - few mts.			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>PUMP FAILURE, RENAL SHUT DOWN - 24 hrs.</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>ASUVD, Atrial fibrillation, CHF - long duration</b>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>12-30-1971</b> to <b>1-2-1972</b>		that <del>the</del> (we) last saw the deceased alive on <b>1-2-1972</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>My</del> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>S.P. GEORGE MD</b>		23B. DATE SIGNED <b>1-2-72</b>		23C. PHYSICIAN'S NAME (Type) <b>S. P. GEORGE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/5/1972</b>		24C. NAME of CEMETERY or CREMATORY <b>OAKLAWN</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones, MD</b>		25C. FUNERAL DIRECTOR <b>Joseph P. Gaddy, Jr., Baltimore, Md.</b>	



B-652

72 00048

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00048

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Muriel A. Burns</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 1 72 1:10 A. M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 1 72 1:10 A. M.</b>			
6. SEX <b>Female</b>				7. RACE <b>White</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Massachusetts</b> B. COUNTY <b>V 18</b>			
9. DATE OF BIRTH <b>July 4, 1908</b>				10. AGE (In years lost birthday) <b>63</b>			
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Edward P. Burns</b>				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			
15. MOTHER'S MAIDEN NAME <b>Mary A. McDermott</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
17. SOCIAL SECURITY NO. <b>011-05-3071</b>				18. INFORMANT ADDRESS <b>Mrs. Dorothy Sullivan Catonsville, Md.</b>			
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>No</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>1-1-72</b>							
24A. BURIAL CREMATION, REMOVAL OR TRANSIT <b>Burial</b>				24B. DATE <b>1/2/72</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Immaculate Conception, Marlboro, Mass</b>				24D. LOCATION (City, town, or county) (State) <b>Marlboro, Mass</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			
25C. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons, Inc.</b>				25D. ADDRESS <b>301 Frederick Rd., Catonsville, Md.</b>			

15281

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00049		72 00049	
S-315				72 00049		72 00049	
BIRTH NO.				72 00049		72 00049	
1. NAME OF DECEASED (Type or Print) <b>Stevenson, Howard Arthur</b>				2. DATE AND HOUR OF DEATH <b>1-1-1972 12:05 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Lutheran Hospital of Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <b>Maryland</b>			
5. SEX <b>Male</b>				6. RACE <b>White</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-14-04</b>			
9. AGE (in years last birthday) <b>67 yrs</b>				10. UNDER 1 Yr. Months Days Under 24 Hrs. Hours Min.			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Arthur Stevenson</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Phumphrey</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-05-2386</b>			
17. INFORMANT <b>Wife</b>				ADDRESS <b>Mae A. Stevenson, 5207 Gwynn Oak Ave., Baltimore, Md. 21207</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cardiogenic Shock</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CCF.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>M.I. Severe anaemia.</b>			
(C) <b>Pneumonia. Lung abscess</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2-1-72</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY (Yes or No) <b>Yes</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21E. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>12-30-71</b> 19 to <b>1-1-</b> 19 <b>72</b>				that (I) (we) last saw the deceased alive on <b>1-1-</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Abdul Majid Memon</b>				23B. DATE SIGNED <b>1-1-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>ABDUL MAJID MEMON MD</b>				23D. ADDRESS <b>730 Ashburton St. Baltimore, Md. 21206</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/4/72</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Lake View Memorial Park</b>				24D. LOCATION (City, town, or county) (State) <b>Sykesville, Carroll, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>			
25C. FUNERAL DIRECTOR <b>Loring Byers</b>				ADDRESS <b>6728 Liberty Road, Randallstown, Md. 21133</b>			

21-11-2

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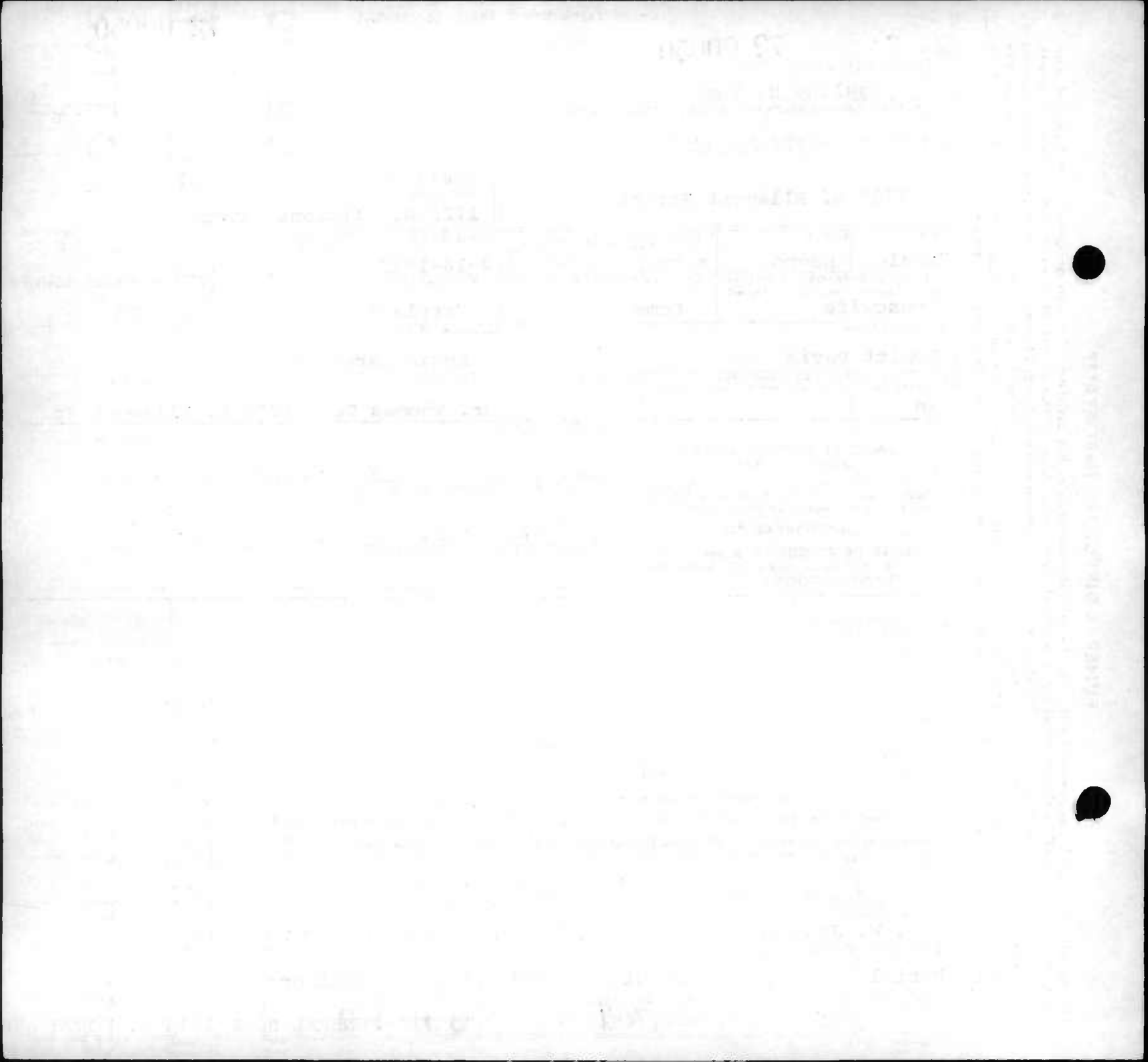
21-11-2



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

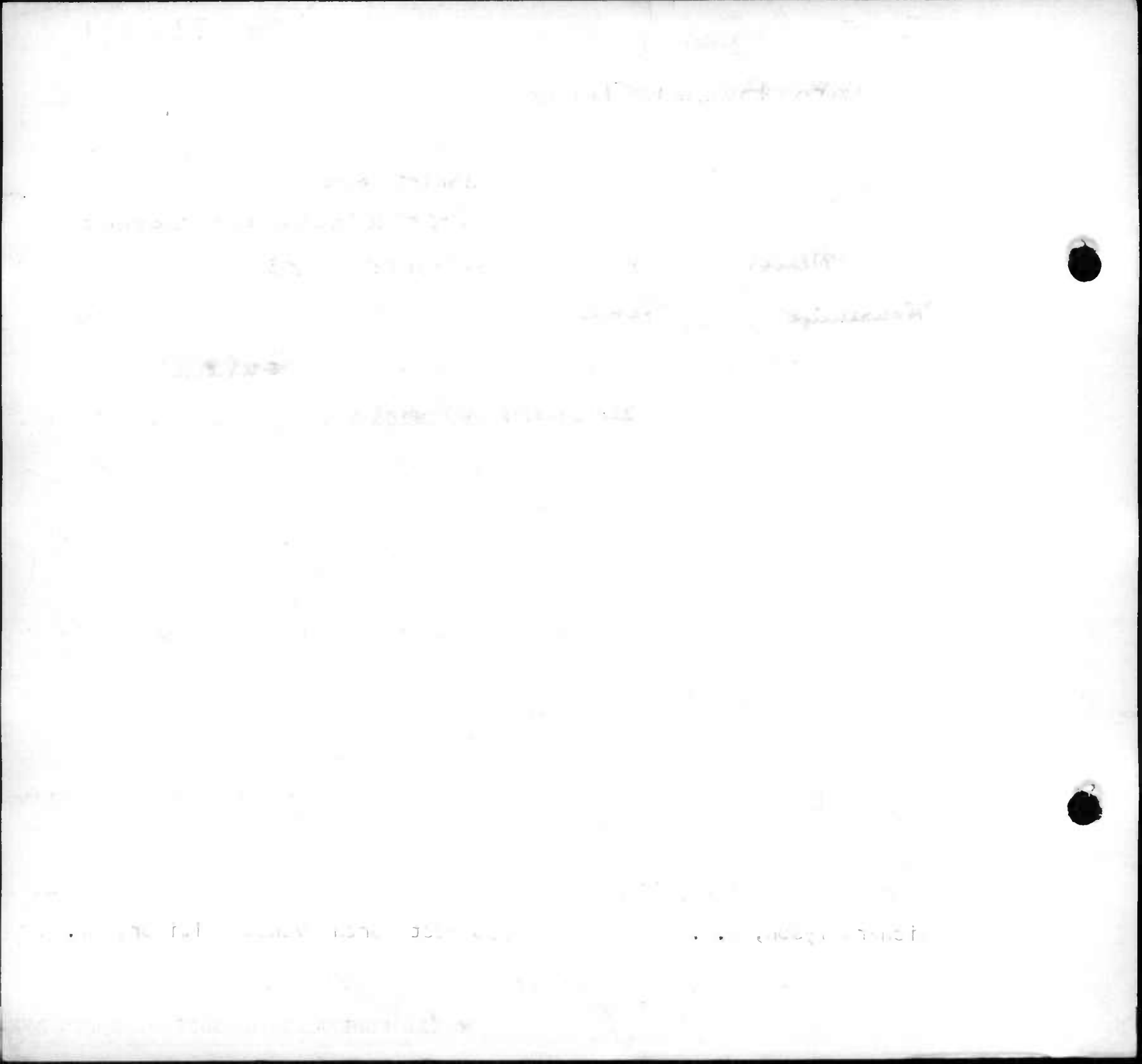
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00050</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>T-400</u> <u>72 00050</u>		2. DATE AND HOUR OF DEATH <u>January 3, 1972</u>			
1. NAME OF DECEASED (Type or Print) <u>Pauline H. Teal</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1729 N. Ellamont Street</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-16-1919</u>		9. AGE (In years last birthday) <u>52</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Emmitt Davis</u>		14. MOTHER'S MAIDEN NAME <u>Addie Barar</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Thomas Teal 1729 N. Ellamont St.</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cornary Thrombosis</u> (B) <u>Hypertensive Vascular Disease</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNOERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> 19 <u>55</u> to <u>Jan 3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. W. Jacobson MD</u>		23B. DATE SIGNED <u>1-4-72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. W. Jacobson</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-6-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>W. D.</u>	
25C. FUNERAL DIRECTOR <u>NOTTER</u>		25D. ADDRESS <u>FUNERAL HOME 3035 W. NORTH AVE</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-625		BALTIMORE CITY HEALTH DEPARTMENT		72 00051	
BIRTH NO.		72 00051		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mary Beulah Truxon		1/3/72 2:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) George Washington N. Home 607 Pennsylvania Ave.		A. STATE Md. B. COUNTY 1605			
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-3-1888		9. AGE (In years last birthday) 83		10. UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) West Point, Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John MARSH		14. MOTHER'S MAIDEN NAME Rebecca Moorehead			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. 220-24-8146		17. INFORMANT Mrs. Hilda Edwards 2408 Winchester St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Housewife Home		CAUSE OF DEATH arteriosclerotic heart disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aortic Aneurysm (B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis (C) UNDERLYING CONDITION last. Minimal Inactive Tuberculosis			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 22 April 19 69 to 3 JAN 19 72 that (2) (we) last saw the deceased alive on 20 Dec 19 71 and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Tyson, M.D.		23B. DATE SIGNED 3 JAN 72		23C. PHYSICIAN'S NAME (Type) Richard Tyson, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-6-1971		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE			



D-500

72 00052

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00052

BIRTH NO.

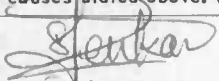
REG. NO.

1. NAME OF DECEASED (Type or Print) Maggie Sadie Dean		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 4 Year 72 Hour 1:14 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month 1 Day 4 Year 72 Hour 1:14 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1703	
9. DATE OF BIRTH Aug 29 - 1902		10. AGE (in years last birthday) 64	
11. BIRTHPLACE (State or foreign country) Accomac Co Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Sample		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT DOMESTIC	
15. MOTHER'S MAIDEN NAME Maggie Haak		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 230-14-1356		18. INFORMANT Tammie Bailey 709 W. Lanvale St	
19. CAUSE OF DEATH 412.4		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 1-4-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/7/72	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Hanshaw & Sons		ADDRESS 1387 Gt. Mt. St	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00053</span>	
D-620 <span style="float: right;">72 00053</span>				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DORSEY, ALPHONSO</b>		2. DATE AND HOUR OF DEATH <b>1/4/1972 at 6:00 A.M.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md 2126</b> B. COUNTY <b>1538</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b> <b>46730 Ashburton Street - Baltimore, Md. 21216</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Boyce</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes World War I</b>		16. SOCIAL SECURITY NO. <b>217-03-9648</b>		17. INFORMANT <b>Mrs. Patricia Holtzclaw 2501 Elsinore</b>	
18. <b>25-0-1</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Septicemia</b>		<b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Diabetes with gangrene of left 4th &amp; 5th toes.</b>			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/20/1971</b> 19 to <b>1/4/1972</b> 19, that (I) (we) lost saw the deceased alive on <b>1/4/1972</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		DEGREE		23B. DATE SIGNED <b>1/4/1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. SURESH PENKAR</b>		23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-7-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Baltimore Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt, Jr.</b>	
25C. FUNERAL DIRECTOR <b>GUTTER FUNERAL HOME</b>		25D. ADDRESS <b>3035 W. NORTH AV</b>			

ORGE

WAT



RELEASED AS NON MED

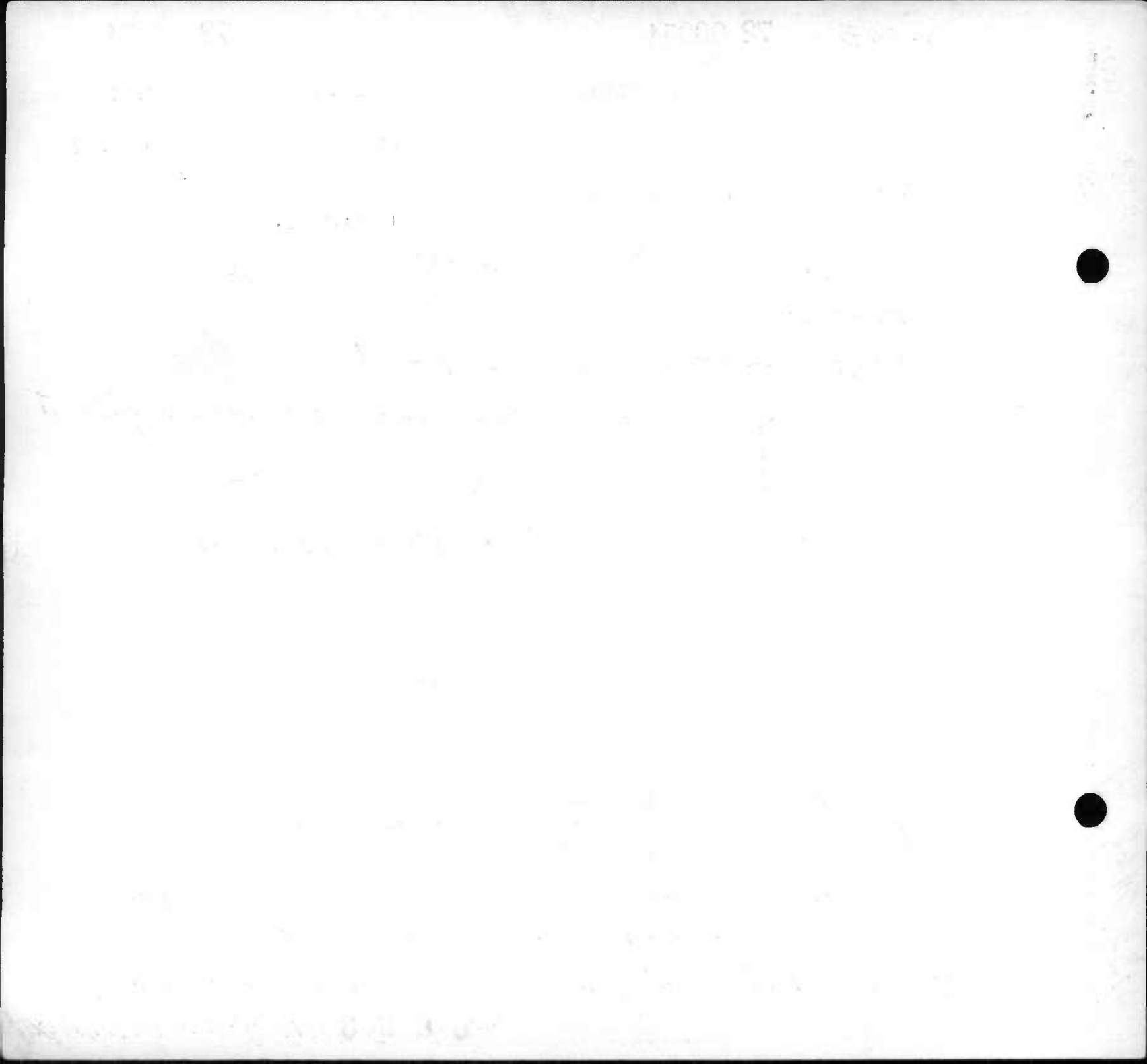
PER DR. SPITZ  
MEDICAL-EXAMINER

FUNERAL DIRECTOR: IMPORTANT

1135 7968  
Smallwood

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-543		72 00054		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00054	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
NOAH SMALLWOOD				1-1-72 1:18 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND 1001			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years lost birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10A. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?				C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER			
MALE NEGRO WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11/23/1867 106 FARMER N.C.				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1012 AISQUITH ST.			
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS			
MARK SMALLWOOD				LYDIA SUSIE SMALLWOOD 1012 Aisquith St			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DEAD ON ARRIVAL			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ? MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				19C. DATE OF OPERATION 19D. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.				22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.			
23A. SIGNATURE 23B. DATE SIGNED				23A. SIGNATURE 23B. DATE SIGNED			
Harvey G. Klein DEGREE 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS				Harvey G. Klein, M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)				24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)			
Burial 1/6/72 Mt. Calvary G.A. County, Md.				Burial 1/6/72 Mt. Calvary G.A. County, Md.			
25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS				25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS			
JAN 5 1972 20054 20054 20054 20054				JAN 5 1972 20054 20054 20054 20054			



K-400

72 00055

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00055

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Thomas Kelly				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 1 72 4:00 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 4:00 A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/15/1931				10. AGE (In years last birthday) 40		11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas Kelly			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Mrs. Frances D. Kelly				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korea			
17. SOCIAL SECURITY NO. 218-26-0333				18. INFORMANT Same			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy Chief Medical Examiner <input checked="" type="checkbox"/> Assistant Medical Examiner <input type="checkbox"/> Associate Medical Examiner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-2-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/5/72			
24C. NAME OF CEMETERY or CREMATORY Arboretum Memorial Park				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972				25B. NAME OF REGISTRAR Robert C. Sullivan, R.D.			
25C. FUNERAL DIRECTOR Gus T. Smith				ADDRESS 1712 W. North Ave			

25000 57

UNITED STATES DEPARTMENT OF THE INTERIOR

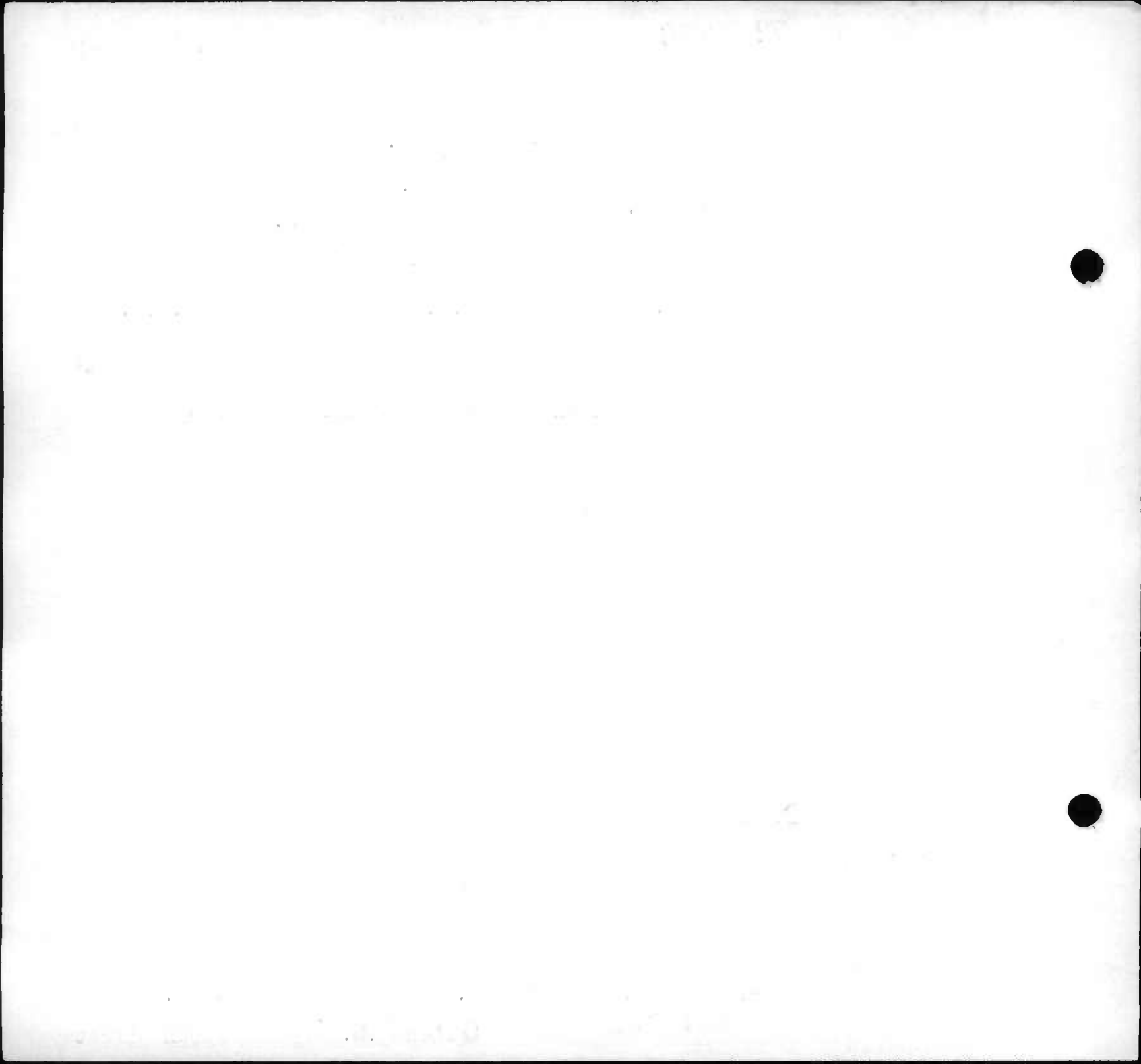
25000 57



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-600 72 00056		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00056	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Farr		1-1-72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		1503	
46 Lutheran Hosp.		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1733 Thomas Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
Male	Negroid		9-18-00	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
retired		Amer. Smelting		S.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward Farr		Mary Davis		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-10-1096		Lillie Gregory same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
162-1 I		Carcinoma of Lung			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19__ to 19__ that (I) (we) last saw the deceased alive on 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Helen Ann Sabunsky					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROSE LORAN M. SABUNSKY		7112 Parkington Ave. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	1-4-72	Mt. Calvary Cem.		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1972		Robert E. Bailey		V. Bailey 1348 Calhoun Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-245</u>		72 00057 BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00057</u>	
1. NAME OF DECEASED (Type or Print) <u>MC ILWAIN, VIOLA</u>			2. DATE AND HOUR OF DEATH <u>1-3-72</u> <u>8:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2716</u>		
5. SEX <u>F</u>			6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>01-09-1941</u>
13. FATHER'S NAME <u>P.D. Lindsay</u>			14. MOTHER'S MAIDEN NAME <u>Laura Hard</u>		9. AGE (In years last birthday) <u>30</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>Pulaski, Tenn.</u>
18. <u>571.0 I</u> CAUSE OF DEATH			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>CIRRHOSIS OF LIVER</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>ALCOHOLISM</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-24</u> 19 <u>71</u> to <u>1-3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-3</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter Oroszlan</u> MD DEGREE				23B. DATE SIGNED <u>1-3-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>PETER OROSZLAN</u> MD DEGREE				23D. ADDRESS <u>3 HAMILL RD. APT 5</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-7-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) <u>Balto, Md.</u>		24E. STATE (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>	
25B. NAME OF REGISTRAR <u>322-4200</u>		25C. FUNERAL DIRECTOR <u>Morton + Dyett F.H.</u>		25D. ADDRESS <u>1701-Hawens St.</u>	







I-12-72 - Letter from - Office of the Chief Medical Examiner, Werner U. Spitz, M.D.  
Deputy Chief Medical Examiner

HRS

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. <u>72 00059</u>		2. DATE AND HOUR OF DEATH <u>Jan. 2, 1972 3 35 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>HOLMES, PAYTON</u>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Phoenix, Md. 21131 003</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1907</u> 9. AGE (In years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Louisa Co, VA.</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>185-09-2512</u>	
17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>		ADDRESS <u>4940 Eastern Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gran Neg Sepsis + Pulmonary</u> <u>Third Degree burns</u> <u>in sufficiency</u> <u>1 1/2 days</u> <u>8 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		None.	
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>PHOENIX, MD 5200</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/25/71 5:30 PM</u>	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fire in HOME -&gt; BURN.</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/25/71</u> to <u>Jan 2 1972</u> , that (I) (we) last saw the deceased alive on <u>Jan 2 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Geoffrey M. Graeber, MD</u>		23B. DATE SIGNED <u>Jan 2, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Geoffrey M. Graeber M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-7-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Stevenson A.M.C. Sparks, Md.</u>		24D. LOCATION (City, town, or county) (State) <u>1st</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, No. 2</u>	
25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u>		25D. ADDRESS <u>1701 - Lawrence</u>	

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U.S.A.

3-5-1944  
James C. Va.  
Unknown

Unknown

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During 1-1-1944  
James C. Va.  
Unknown

72-00060  
K-263

BALTIMORE CITY HEALTH DEPARTMENT

72 00060

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ernest Richards				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 3 Year 72 Hour 10:00 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital				3. DATE PRONOUNCED DEAD Month 1 Day 3 Year 72 Hour 10:00 P. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-6-1917				10. AGE (In years last birthday) 54		11. BIRTHPLACE (State or foreign country) Pasadena, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Clemons Spencer			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				15. MOTHER'S MAIDEN NAME Eva Richards			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. 218-05-4429		18. INFORMANT Agatha Williams	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Werner U. Spitz</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-4-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-6-72		24C. NAME of CEMETERY or CREMATORY Magathy Meth Cemetery		24D. LOCATION (City, town, or county) (State) Magathy, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR P. B. C. J. R. R. D.		25C. FUNERAL DIRECTOR Montgomery Dwyett F. H.		25D. ADDRESS 1701 Laurens St.	



72 00061  
C-400

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00061

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE COLE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1760 E. North Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 3 1972 11:32a</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>805</b>	
9. DATE OF BIRTH <b>Aug 15, 1918</b>		10. AGE (In years last birthday) <b>53</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Cloud, South Carolina</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
13. FATHER'S NAME <b>Unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Bessie Cole</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs. Queen E. Cole 2104 E. Federal St.</b>	
19. <b>0113</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Active pulmonary tuberculosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>PARTIAL</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-3-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-7-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Russell S. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St.</b>	



SECRET

SECRET

100 E. Foster Ave.

Atlanta

State, South Carolina

Box 10

Mr. Quinn E. Cobb, 101 E. Foster Ave.

Active member, Subversive

*[Handwritten signature]*

Quinn E. Cobb, 101 E. Foster Ave.

100 E. Foster Ave.

State, South Carolina

Mr. Quinn E. Cobb, 101 E. Foster Ave.



72 00062 G-625		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 00062	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) SHIRLEY GARRISON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 29 Provident Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 3 1972 7:20 a.m.			
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 1403				6. SEX female 7. RACE negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH 10-27-25 10. AGE (In years lost birthday) 46 11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Smith				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
15. MOTHER'S MAIDEN NAME Margaret Clark				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO. 217305055				18. INFORMANT Margaret Taylor ADDRESS same			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-3-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-7-72 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. 24D. LOCATION (City, town, or county) (State) Balto., Md.							
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun St.							

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>
L-162 <span style="background-color: black; color: black;">[REDACTED]</span> 72 00063		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO. <span style="background-color: black; color: black;">[REDACTED]</span>		1. NAME OF DECEASED (Type or Print) <b>JOHN T. LYVERS</b>		
2. DATE AND HOUR OF DEATH		<b>JAN. 5, 1972 5:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Maryland</b>		
<b>Pleasant Manor Nursing Home</b>		B. COUNTY <b>1502</b>		
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>1635 N. Fulton Av.</b>				
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/00</b>	9. AGE (In years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME <b>MARY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		
16. SOCIAL SECURITY NO. <b>474-03-1695</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>1635 N. Fulton</b>		
18. <b>410.9 14 250.9</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>		
ANTECEDENT CAUSES		(B) <b>Arteriosclerotic Heart Dis.</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Diabetes Mellitus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> 19 <b>71</b> to <b>1/5</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>1/5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>D. W. Stewart, M.D.</b>		23B. DATE SIGNED <b>1/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>D. W. STEWART, M.D.</b>
23D. ADDRESS <b>2300 Garrison Blvd. (21216)</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1-8-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Beck</b>		25C. FUNERAL DIRECTOR <b>Beck</b> ADDRESS <b>1348 N. Calhoun St.</b>

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(over)

Bureau of the Census, 1880

M-35072 00064  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALBERT MADDEN Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year 1 2 1972		Hour 4:20 p.m.	
6. SEX male		7. RACE negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8-16-04		10. AGE (In years last birthday) 67		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Madden Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	
15. MOTHER'S MAIDEN NAME Mamie Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mamie Madden		19. ADDRESS same		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		23. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 1600 blk. N. Milton Ave.	
24. TIME (Month) (Day) (Year) (Hour) 12-8-71 6:33 a.m.		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		26. HOW DID INJURY OCCUR? Pedestrian struck by auto.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-3-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-72		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.			

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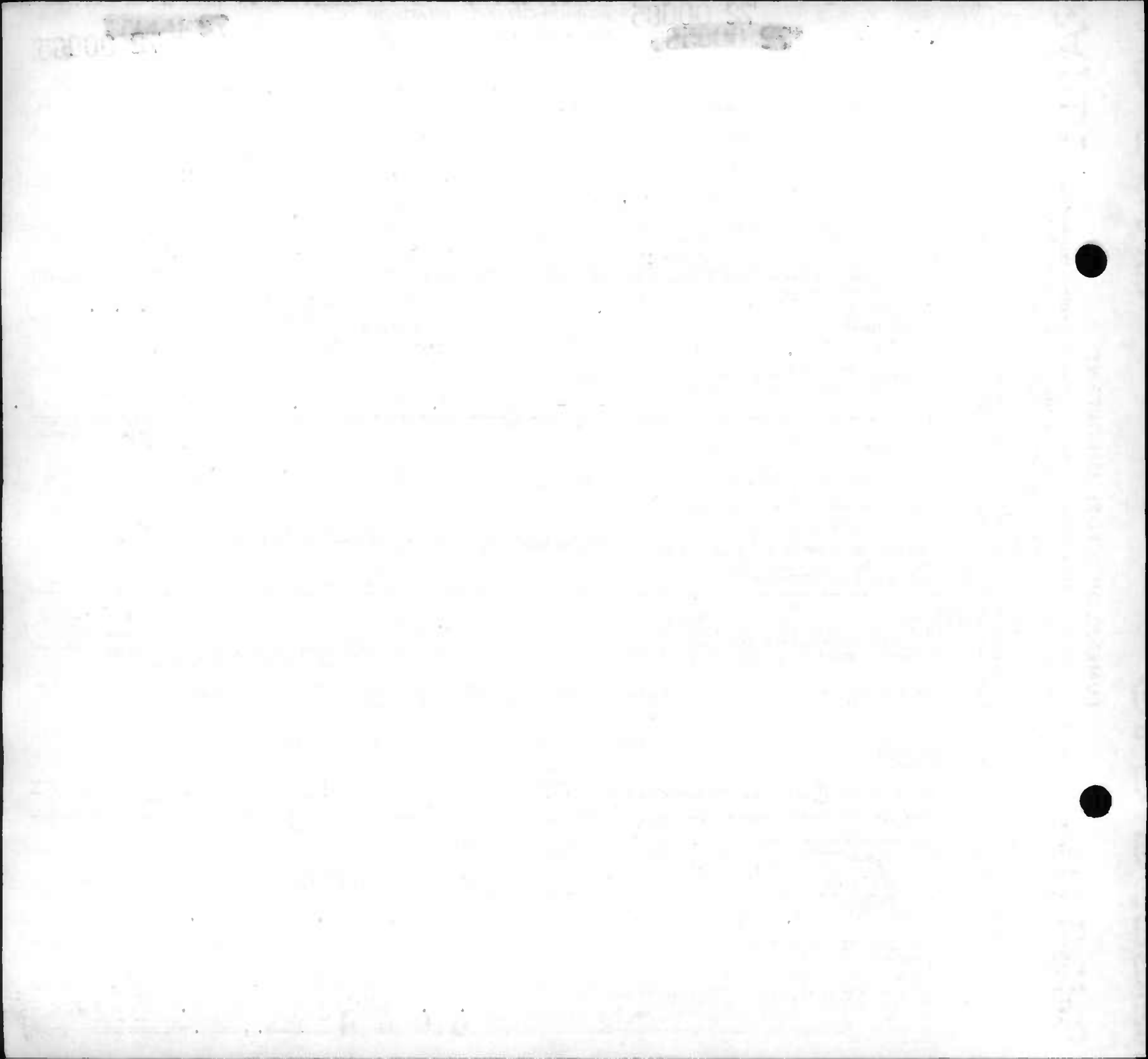
*Handwritten signature*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">72 00065</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">Thomas Benton Shafer</span>		<b>2. DATE AND HOUR OF DEATH</b> January 3, 1972   4 P.M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <div style="text-align: center; font-size: 2em;">00</div> 210 Laurens St.		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">1401</span> <b>C. CITY OR TOWN</b> <span style="float: right;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> 210 Laurens St.		
<b>5. SEX</b> M	<b>6. RACE</b> W	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 12/17/1904	<b>9. AGE</b> (In years last birthday) 67
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Bureau of Collections Balto. City		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Maryland		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.
<b>13. FATHER'S NAME</b> Richard F. Shafer		<b>14. MOTHER'S MAIDEN NAME</b> Mary Helen Orndorff		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 215-07-0942		<b>17. INFORMANT ADDRESS</b> Mrs. Richard N. Stein 1314 Bolton St.
<b>CAUSE OF DEATH</b>				
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>(A) IMMEDIATE CAUSE</b> <span style="float: right;">Congestive Heart Failure</span> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) ARTERIO-SCLEROTIC Heart Disease</b> <span style="float: right;">years</span> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b> <span style="float: right;">month</span>		
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (X) (this hospital) attended the deceased from 19 65 to 1-3 19 72 that (I) (we) last saw the deceased alive on Jan 2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Luis F. Gonzalez</span>				<b>23B. DATE SIGNED</b> 1-4-72
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="float: right;">Dr. Luis Gonzalez</span>		<b>23D. ADDRESS</b> 39th & St. Paul Sts.		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Cremation		<b>24B. DATE</b> 1/5/72		<b>24C. NAME of CEMETERY or CREMATORY</b> Greenmount
<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Md.		<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 5 1972		
<b>25B. NAME OF REGISTRAR</b> Robert E. [unclear]		<b>25C. FUNERAL DIRECTOR ADDRESS</b> H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212		









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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00067</u>	
S-516 BIRTH NO. <u>72 00067</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>NELLIE P SANFORD</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 1 1972 3:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION! <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1204</u>			
5. SEX <u>W</u> F		6. RACE <u>F</u> W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNK</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>06-20-1886</u> 9. AGE (In years last birthday) <u>85</u>	
11. BIRTHPLACE (State or foreign country) <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-1242</u>		17. INFORMANT <u>Henry Patterson</u> ADDRESS <u>1205 Windy Gate Rd.</u>	
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>VEGETRAL THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIOESCLEROSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>71</u> to <u>1/1</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CEOR VIZURAN</u>		23D. ADDRESS <u>33rd and Calvert St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>1/3/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	
24D. LOCATION <u>Greenmount Ave Balto</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u> ADDRESS <u>Home 6500 York Rd.</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00068	
B-252 72 00068				1. NAME OF DECEASED (Type or Print) <b>BECKENSTEIN, JAKE. JACK</b>		2. DATE AND HOUR OF DEATH <b>1/2/72 6:12 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>				A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1/2/72</b>		9. AGE (in years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster, Pa</b>	
13. FATHER'S NAME <b>Harry Beckenstein</b>				14. MOTHER'S MAIDEN NAME <b>Jola ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>3-5227</b>		17. INFORMANT <b>Mrs. Clara Beckenstein</b> ADDRESS <b>6938 Brookmill Rd T-2</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.91</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic H. Disease</b> <b>years</b>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b> <b>days</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <b>Severe infection</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At <input type="checkbox"/> Work Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> 19 <b>71</b> to <b>1/2</b> 19 <b>72</b> that (we) last saw the deceased alive on <b>1/2</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>1/2/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Manseur H.D.</b>				23D. ADDRESS <b>Sinai Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/3/72</b>		<b>Lubawitz</b>		<b>Rosedale, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey, M.D.</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>6010 Keast Rd.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHESLOW, NATHAN LOUIS

2. DATE AND HOUR OF DEATH

JANUARY 1, 1972 11:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

21215

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)ST AGNES HOSPITAL  
CATON & WILKENS AVENUES  
BALTIMORE, MARYLAND 21229

C. CITY/TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

6952 MILBROOK PARK DRIVE

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

08/15/08

9. AGE (In years  
(last birthday))

63

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Pharmacist

10B. KIND OF BUSINESS OR INDUSTRY

Retail

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LOUIS CHESLOW

14. MOTHER'S MAIDEN NAME

RACHEL

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

BALTO MD 21229

ADDRESS

ST AGNES' RECORDS CATON &amp; WILKENS AVES

18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		

MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1/12/30/71	Gangrenous Avascular Les	NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 17 19 71 to JANUARY 1 19 72 that (X) (we) last saw the deceased alive on JANUARY 1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE			23B. DATE SIGNED
Leroy B Buckler, M.D.			1/2/72
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
LEROY B BUCKLER, M.D.		BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/3/72	Burial	Balto, Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 5 1972	Robert J. ...	Robert J. ...	6016 Regt Rd

1/17/72 - Letter from St. Agnes Hospital. Signed by Marie L. Moyer, Adm. Sup.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the registration can be completed.

J-520		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00070	
BIRTH NO. 72 00070		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHNS EMMA</b>		2. DATE AND HOUR OF DEATH <b>7.15 AM, 1, 4, 1972 7.15 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b> <b>43</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>502 Fairfax Ave.</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-94</b>	9. AGE (In years last birthday) <b>77</b>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
13. FATHER'S NAME <b>Henry HANNIG (Dec)</b>		14. MOTHER'S MAIDEN NAME <b>Bernadina HANNIG</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>304-72-7638 D</b>		17. INFORMANT <b>Son</b> ADDRESS <b>502 FAIRFAX AVE.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc., means the disease, injury or complication which caused death.) <b>Extensive decubitus ulcer</b>		CAUSE OF DEATH 1. CONGESTIVE HEART FAILURE 2. SEVERE HYPOTENSION 3. EXTENSIVE DECUBITUS ULCER (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Coronary Occlusive</b> (B) <b>Ex. Rt. hip</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Senility</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>One Month</b> <b>1 Month</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Extensive Decubitus Ulcer</b>			
19A. DATE OF OPERATION <b>12-13-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>decubitus ulcer</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) <b>(Yes)</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Baltimore City</b>	
21D. TIME OF INJURY (APPROX.) <b>11-10-71 (7pm)</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>walking to the bathroom.</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>11-10-71</b> to <b>1-4-72</b> and that (I) (we) last saw the deceased alive on <b>1-4-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. J. Salmasie</b>		23B. DATE SIGNED <b>1-4-72</b>		23C. PHYSICIAN'S NAME (Type) <b>J. J. Salmasie</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-7-72</b>		24C. NAME of CEMETERY or CREMATORY <b>OAK HILL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>John E. Galley, M.D.</b>		25C. FUNERAL DIRECTOR <b>HANN FUNERAL Home</b> ADDRESS <b>BALTO, 4200 Pennington</b>	

RECEIVED

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		72 00071	
MR. FRANK M. COSTIN		12 172		1 5:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD		B. COUNTY 7	
MARYLAND GENERAL HOSP 48		C. CITY OR TOWN CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1104 W. Hamburg ST					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-14-11	9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUTTER		10B. KIND OF BUSINESS OR INDUSTRY Schretel Sns		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James M. Costin		14. MOTHER'S MAIDEN NAME Daisy Benny	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Chart	
18. ADDRESS 472-41		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure			
(C) ASCVD					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12 172 to 12 72 19 72		that (I) (we) last saw the deceased alive on 11 19 72 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George C. Sammons MD		23B. DATE SIGNED 1/2/72			
23C. PHYSICIAN'S NAME (Type) George C. Sammons MD		23D. ADDRESS MCH			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-6-72		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR John J. Covatta & Son Inc. 901 Hollins St. Balt. Md.	

100-100000

100-100000

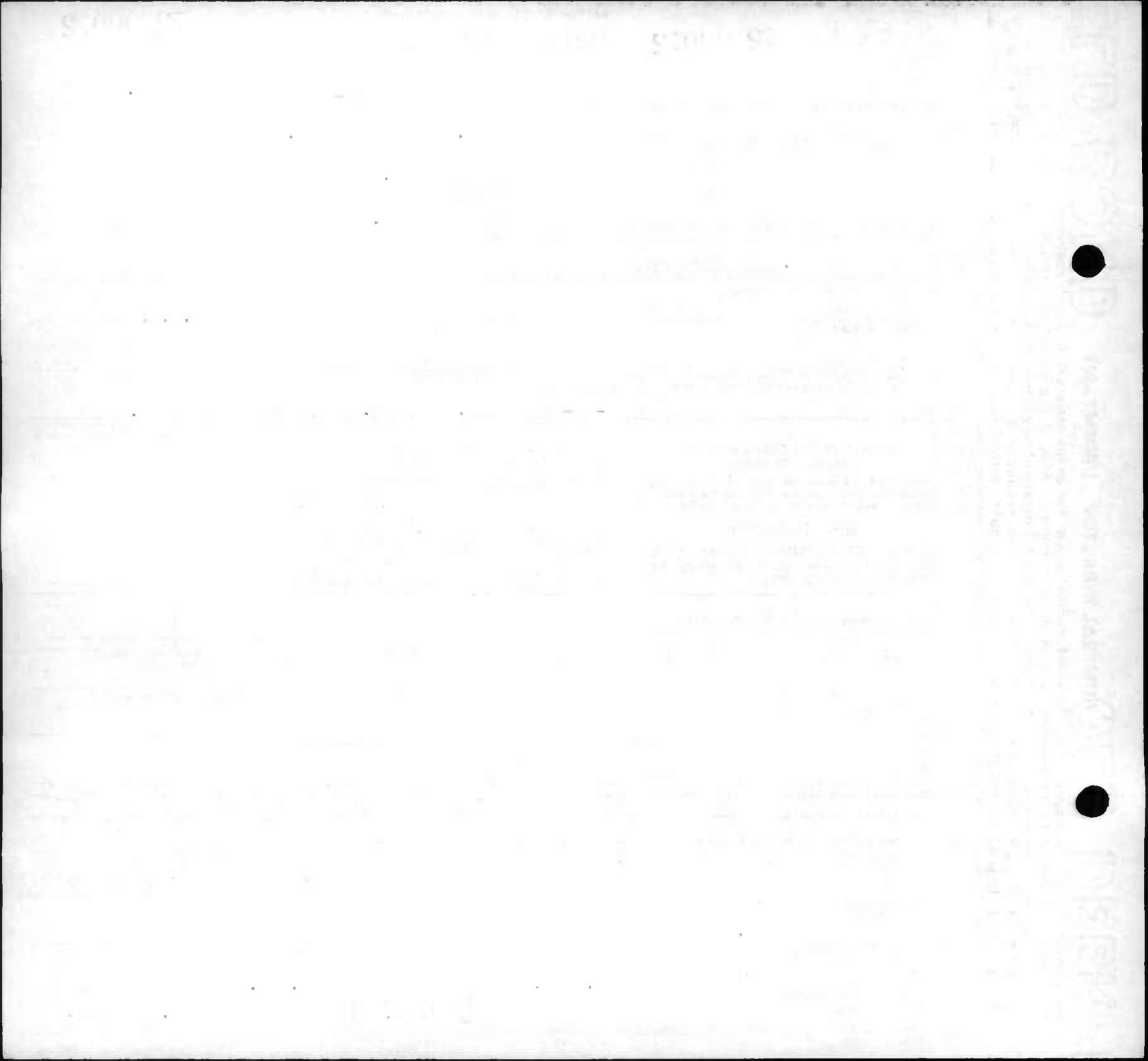
100-100000



# FUNERAL DIRECTOR: IMPORTANT

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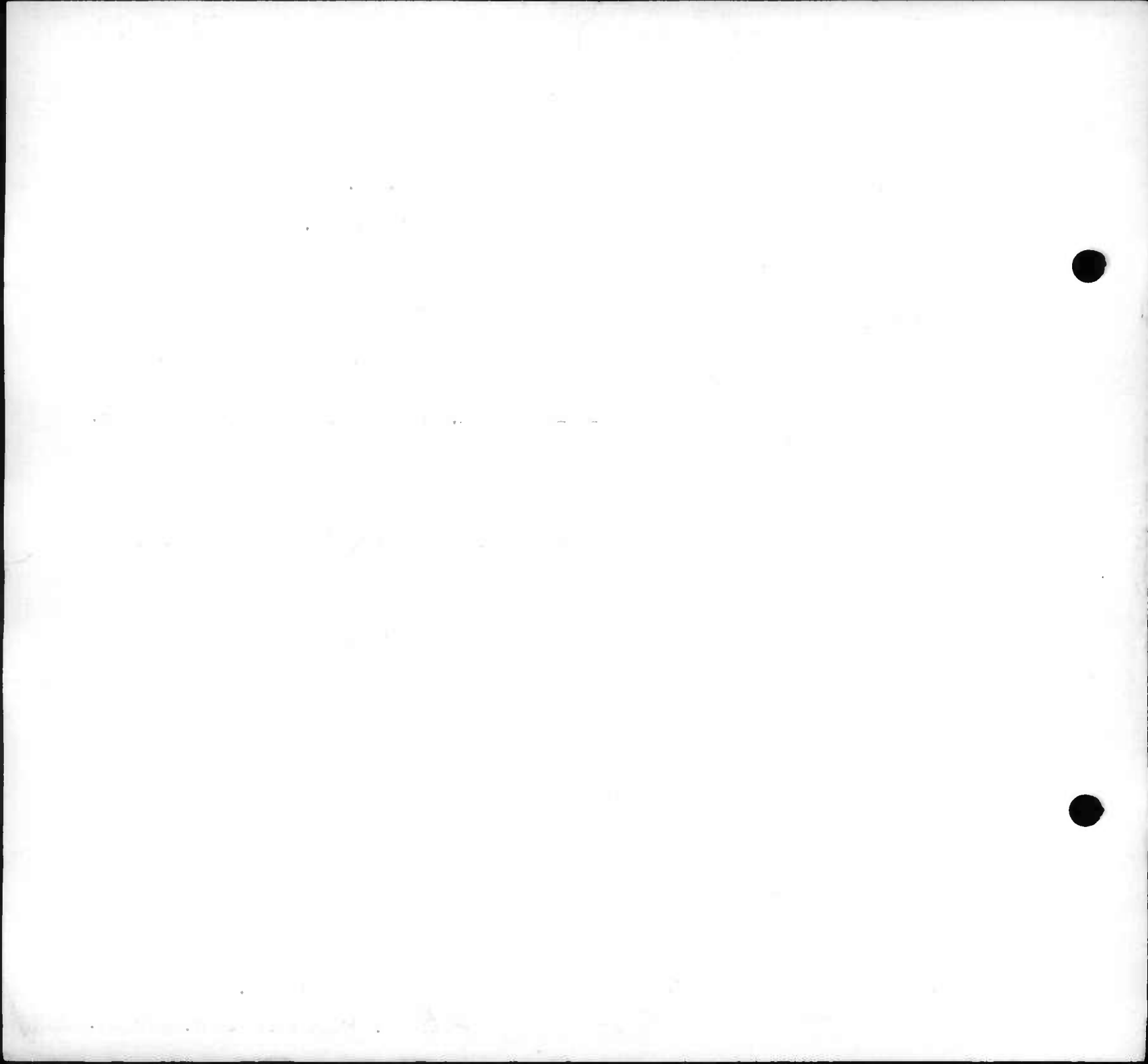
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00072</span>	
I-564 72 00072				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Tannarelli, MICHAEL</u>		2. DATE AND HOUR OF DEATH <u>1-2-72</u> <u>1.15</u> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <u>MERCY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>922 FAWN ST.</u>			
5. SEX <u>M</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/1890</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>LONDON ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ANTHONY TANNARELLI</u>			
14. MOTHER'S MAIDEN NAME <u>SCOLASTICO FUSCO</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-01-1542a</u>		17. INFORMANT <u>MRS. MARIA C. HELOWICZ 922 FAWN ST.</u>			
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial infarction</u> (B) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 18</u> 19 <u>72</u> to <u>Jan 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Lee</u>		23B. DATE SIGNED <u>Jan 2-1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR. LEE</u>		23D. ADDRESS <u>BALTO. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/6/72</u>		24C. NAME of CEMETERY or CREMATORY <u>NEW CATH. CEM.</u>	
24D. LOCATION (City, town, or county) <u>BALTO. Md.</u>		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Lee, M.D.</u>		25C. FUNERAL DIRECTOR <u>BROME M. DELLA NOCE</u>	
25D. ADDRESS <u>322 S. HIGH ST.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-525		72 00073		BALTIMORE CITY HEALTH DEPARTMENT		72 00073	
BIRTH NO.		72 00073		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>TOMASINO, SANTINA</u>				2. DATE AND HOUR OF DEATH <u>1/2/72</u> <u>BALTO</u> <u>5:20 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSP.</u>				A. STATE <u>BALTO, Md.</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTO. md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
48				E. STREET AND NUMBER <u>5609 PEMBROKE AVE.</u>		<u>5300</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/17</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GENTILE VINCENT</u>				14. MOTHER'S MAIDEN NAME <u>ROSA BELFIORE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-1316</u>		17. INFORMANT <u>MR. LELIO TOMASINA</u> ADDRESS <u>5609 PEMBROKE AVE.</u>			
18. <u>734.1 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Sup and Hepatitis &amp; Nephritis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Systemic Lupus Erythematosus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u>		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael G. Foulkes</u> M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS				23E. DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		24B. DATE <u>1/6/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>LORRAINE PARK</u>		24D. LOCATION (City, town, or county) (State) <u>WOODLAWN Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>GEROME M. DELLA NOCE</u>		25D. ADDRESS <u>322 S. HIGH ST.</u>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Eddie Foster or Edward C. Foster</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 3 72 4:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3208 Piedmont Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 3 72 4:55 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1537</b>	
9. DATE OF BIRTH <b>3/30/15</b>		10. AGE (In years lost birthday) <b>56</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Foster</b>		14. MOTHER'S MAIDEN NAME <b>Lillian</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>220-03-9098</b>	
18. INFORMANT <b>Pearl Foster</b>		ADDRESS <b>3208 Piedmont Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/8/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Charles A. Rice</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661W. Barre St.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">S-300</p> <p style="font-size: 24pt; margin: 0;">72 00075</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <u>72 00075</u></p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>SCOTT SAMUEL</u></p>		<p>2. DATE AND HOUR OF DEATH</p> <p><u>1/31/72</u> at <u>3 30</u> P. M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>46 Lutheran Hospital</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE <u>MD.</u> B. COUNTY <u>1503</u></p> <p>C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>5122 Presbury St.</u></p>			
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>Negro</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>1-10-24</u></p>	<p>9. AGE (In years last birthday) <u>47</u></p>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>PORTER</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><u>Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A.</u></p>		<p>13. FATHER'S NAME</p> <p><u>Unk.</u></p>		<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Unk.</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>Yes</u> <u>WW II</u></p>		<p>16. SOCIAL SECURITY NO.</p> <p><u>217-12-9605</u></p>		<p>17. INFORMANT ADDRESS</p> <p><u>SON - Samuel Scott Same</u></p>	
<p>18. <u>431.9 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p><u>Cerebrovascular Accident, →</u></p> <p>(A) IMMEDIATE CAUSE</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>Cerebral Haemorrhage.</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>11/31/1972</u> to <u>11/31/1972</u> that (I) (we) last saw the deceased alive on <u>11/31/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE</p> <p><u>Anjana Doshi M.D.</u></p>		<p>23B. DATE SIGNED</p> <p><u>1/31/72</u></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>ANJANA DOSHI M.D.</u></p>		<p>23D. ADDRESS</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>		<p>24B. DATE</p> <p><u>1-7-71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY</p> <p><u>Baltimore National</u></p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p><u>Baltimore, Maryland</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>JAN 5 1972</u></p>			
<p>25B. NAME OF REGISTRAR</p> <p><u>Charles A. Rice</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p> <p><u>661 N. Barre St.</u></p>			

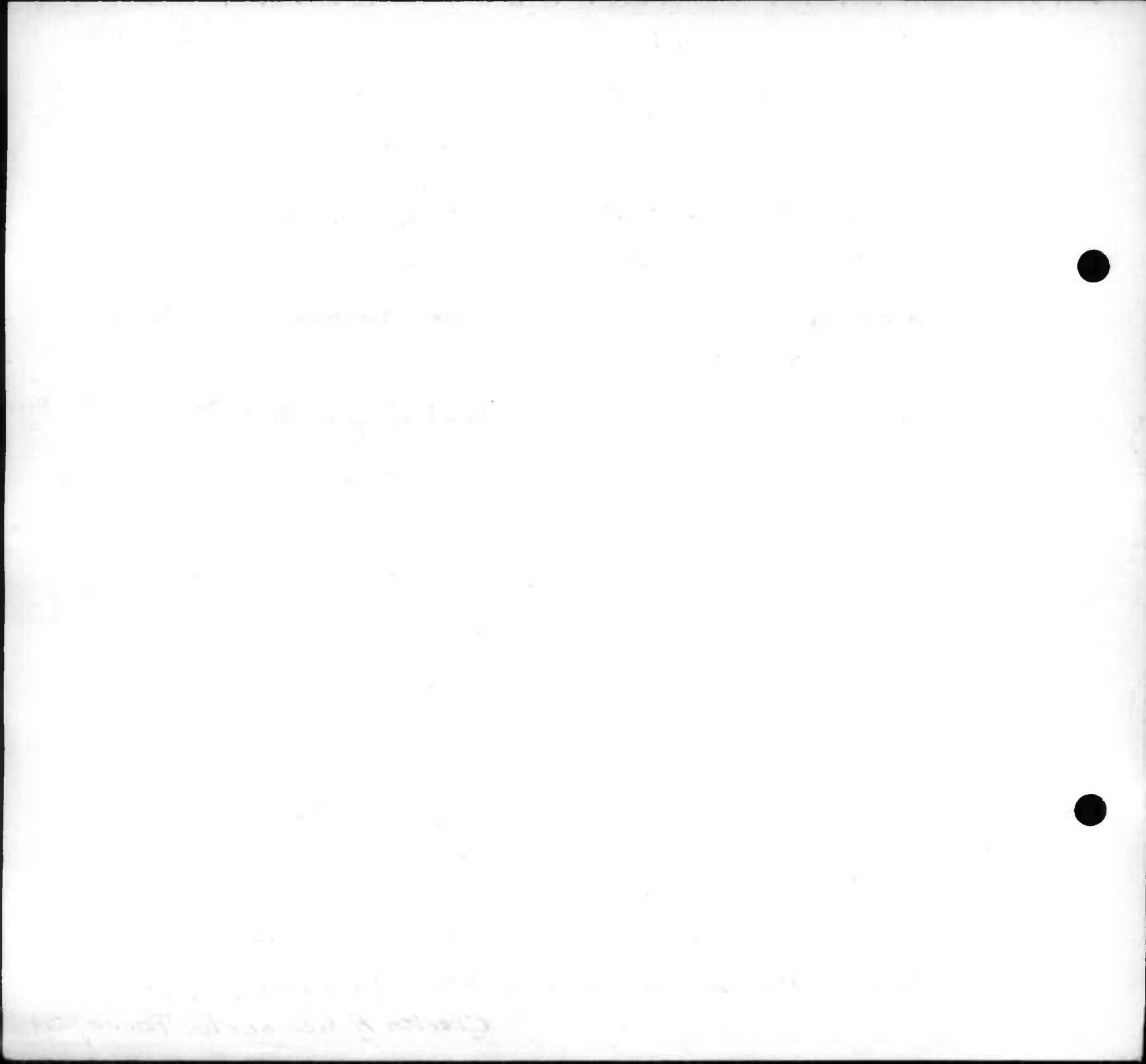
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-623 72 00076		CERTIFICATE OF DEATH		72 00076	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
Janna Wright		1-3-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		A. STATE Maryland		B. COUNTY 1604	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/26/13		9. AGE (In years last birthday) 58		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME John Lockett		14. MOTHER'S MAIDEN NAME Kate Lacy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT John L. Wright (Son)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) Uremia (C) Chronic + Acute Renal Insufficiency 1 yr		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Paroxysmal Ectasia					
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/28 1971 to 1/3 1972 that (I) (we) last saw the deceased alive on 1/3 1972 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard L. Taw Jr. MD		23B. DATE SIGNED 1/3/72		23C. PHYSICIAN'S NAME (Type) Richard L. Taw, Jr. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-8-72		24C. NAME OF CEMETERY or CREMATORY Pocahontas Cem.	
24D. LOCATION Farmville, Virginia		24E. FUNERAL DIRECTOR Charles W. Rice		24F. ADDRESS 661 W. Barro St.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR John L. Wright		25C. FUNERAL DIRECTOR Charles W. Rice	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300 72 00077		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00077	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Gertrude White</i>		2. DATE AND HOUR OF DEATH <i>1/3/72</i> <i>3:45</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>2201</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>George Washington Nursing Home 607 Pennsylvania Ave</i>				C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>530 S. HANOVER ST.</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <i>Separated</i> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/13/1900</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South hill, Va.</i>	
13. FATHER'S NAME <i>Will Lambert</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				14. MOTHER'S MAIDEN NAME <i>Alice Ogden</i>	
16. SOCIAL SECURITY NO. <i>218-09 0883</i>		17. INFORMANT <i>Chart.</i>		ADDRESS <i>607 Pennsylvania</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Arteriosclerotic Cardiovascular Disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Stroke</i> (B) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i> <i>1969</i> <i>3 years</i> <i>3 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>14 Oct</i> 19 <i>70</i> to <i>3 JAN</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>31 Dec</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard Tyson, M.D.</i> DEGREE				23B. DATE SIGNED <i>3 Jan 72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard Tyson, M.D.</i> DEGREE				23D. ADDRESS <i>Baltimore, Md. 21217 936 West North Avenue</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1-5-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE RECEIVED BY HEALTH DEPT. <i>JAN 5 1972</i>		24F. NAME OF REGISTRAR <i>Charles A. Rice</i>	
24G. ADDRESS <i>661 W. Parre St.</i>		24H. FUNERAL DIRECTOR		24I. ADDRESS	

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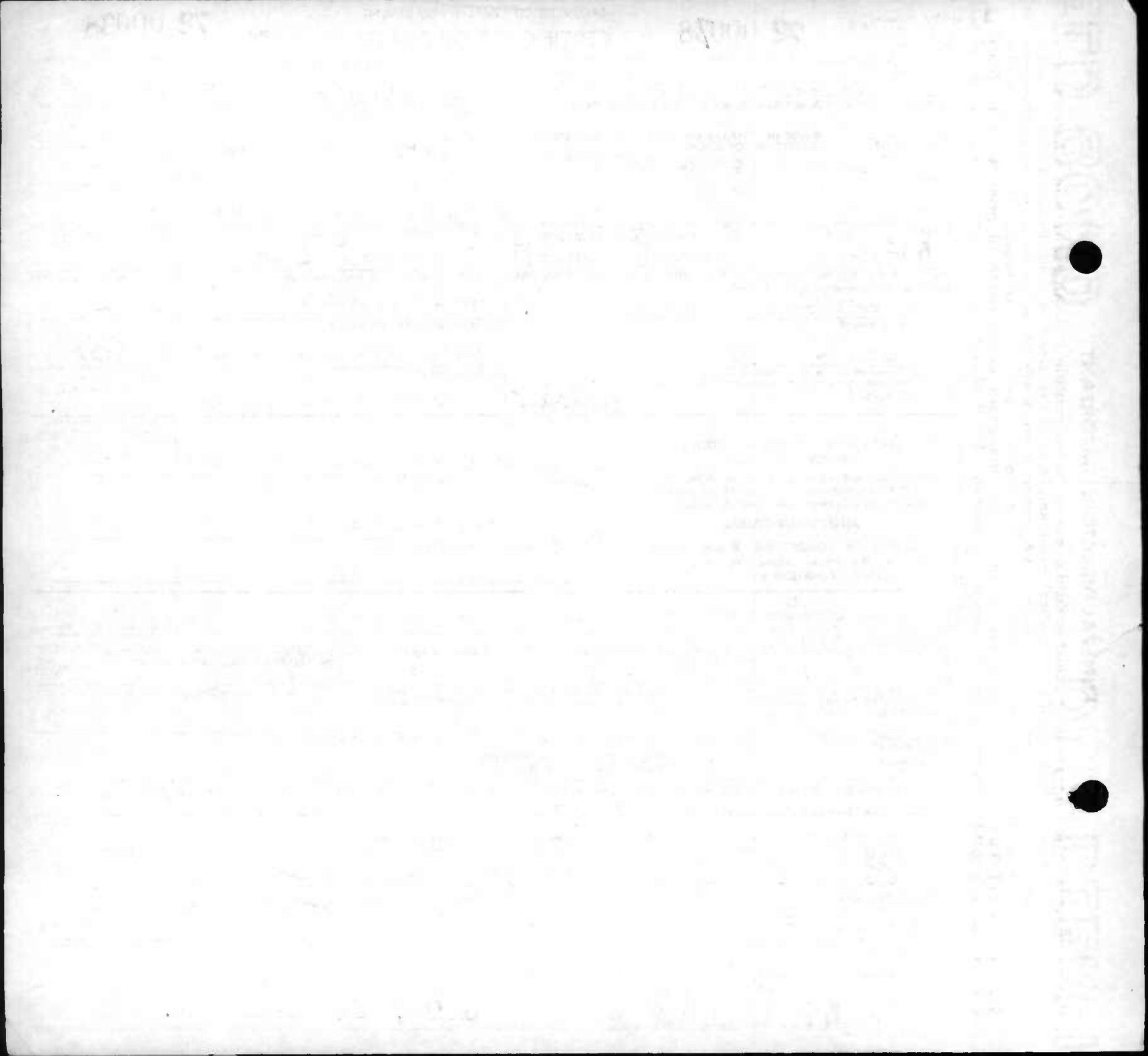
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00228 00078</u>	
Y-520 72 00078				CERTIFICATE OF DEATH	
BIRTH NO. <u>72 00078</u>		1. NAME OF DECEASED (Type or Print) <u>WILLIAM YANKE</u>		2. DATE AND HOUR OF DEATH <u>1/3/72 9:00 A</u>   <u>9:00 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>		5. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>		E. STREET AND NUMBER <u>5438 CHANNING RD.</u>			
5. SEX <u>MALE</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-06</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>League Lumber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ADULIUS (D)</u>		14. MOTHER'S MAIDEN NAME <u>WILHELMINA KINTOP (D)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>215-05-8605</u>		17. INFORMANT <u>WIFE Carrie Yanke</u> ADDRESS <u>21229 Channing Rd.</u>	
18. <u>562.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE CARDIAC FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MYOCARDIAL INFARCTION</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>1 hour.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>BLEEDING DIVERTICULOSIS POST COLLECTORY</u>		19A. DATE OF OPERATION <u>1/2/30/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BLEEDING DIVERTICULOSIS</u>	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-25-71</u> 19 <u>71</u> to <u>1/3</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>1/3/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cesar F. Climaco M.D.</u>		23B. DATE SIGNED <u>1/3/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CESAR F. CLIMACO MD</u>		23D. ADDRESS <u>2502 W. Potomac Ave. Balto. Md.</u> <u>21230</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/7/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	
24D. LOCATION <u>Woodlawn, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		24F. NAME OF REGISTRAR <u>Witake</u>	
24G. FUNERAL DIRECTOR <u>2630 Edmondson Ave.</u>		24H. ADDRESS <u>21228</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. <u>200079</u>			
M-000 72 00079													
BIRTH NO.													
1. NAME OF DECEASED (Type or Print) <b>MAYHEW ELMER JOHN SR</b>					2. DATE AND HOUR OF DEATH <b>01/01/72 8:15AM</b>								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2957 BERO RD 21227</b>								
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01/06/00</b>		9. AGE (In years last birthday) <b>71</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>JOHN MAYHEW</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH FULMER</b>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>215 03 3393</b>		17. INFORMANT <b>ST AGNES HOSPITAL BALTO MD 21229</b>					ADDRESS	
18. EXAMINED BY <b>412.441-8885X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTICIPATED CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last					CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>subdural hematoma</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
19A. DATE OF OPERATION <b>1/12/21/71</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>subdural hematoma</b>					20A. AUTOPSY (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>yes</b>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>home</b>					21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) <b>home</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>12/13/71</b>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					21F. HOW DID INJURY OCCUR? <b>fall - found unconscious</b>			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/13/71</b> 19 to <b>01/01/72</b> 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>01/01/72</b> 19 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (view) the body after death.													
23A. SIGNATURE <b>C.R. Chaney</b>					23B. DATE SIGNED <b>10/ 01/01/72</b>								
23C. PHYSICIAN'S NAME (Type) <b>C. R. CHANEY, M.D.</b>					23D. ADDRESS <b>BALTO., MD. 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVES</b>								
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>1/5/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy Balto Md. 21225</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>					25B. NAME OF REGISTRAR <b>John A. ...</b>					25C. FUNERAL DIRECTOR ADDRESS <b>McCully Funeral Home 237 Patapsco Ave 21225</b>			

MEMO

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

C-653

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00080

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

WILLIAM C. D. GRUND

## 2. DATE OF DEATH

Known ☐Estimated ☐

Month

Day

Year

Hour

M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 314 N. Robinson Street

## 3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

## 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE Maryland

B. COUNTY

601

## 6. SEX

Male

## 7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

12/7/'95

## 10. AGE (in years lost birthday)

76

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

## E. STREET AND NUMBER

314 N. Robinson Street

## 11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Charles L. Grund

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

## 14B. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

## 15. MOTHER'S MAIDEN NAME

Margaret Knight

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WWI

## 17. SOCIAL SECURITY NO.

228-18-768

## 18. INFORMANT

## ADDRESS

Mr. Charles L. Grund 3423 Lyndale Ave.

## 19.

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

## OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/5/72

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

1/8/82

## 24C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

## 24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

## 25A. DATE REC'D BY HEALTH DEPT.

JAN 6 1972

## 25B. NAME OF REGISTRAR

Baltimore City Health Department

## 25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St

## ADDRESS

25 JAN 1981

25 JAN 1981

25 JAN 1981

25 JAN 1981



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00081</span>	
R-300 72 00081				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James Wilson Reid		1-3-72 11:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Sparrows Point		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 1109 H. Street		21219
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1901	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Smelter Foreman		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Reid		14. MOTHER'S MAIDEN NAME Mary Ann Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-9501A		17. INFORMANT Records: BCH-4940 Eastern Ave. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE PROBABLE MYOCARDIAL INFARCTION (B) HYPOTENSION (C) RECURRENT HEMORRHOIDAL ACUTE  II POST OP AORTIC ANEURYSM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE ACUTE ACUTE 1 MONTH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-12-1972 to 1-3-1972 that (I) (we) last saw the deceased alive on 1-3-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wayne Leadbetter		23B. DATE SIGNED 1-3-72		23C. PHYSICIAN'S NAME (Type) Wayne Leadbetter	
23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224		23E. PHYSICIAN'S NAME (Type) Wayne Leadbetter		23F. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-6-72		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gardens	
24D. LOCATION Cockeysville, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 6 1972		24F. NAME OF REGISTRAR John J. Duda	
24G. FUNERAL DIRECTOR John J. Duda		24H. ADDRESS 7922 Wise Ave. Dundalk, Md.			

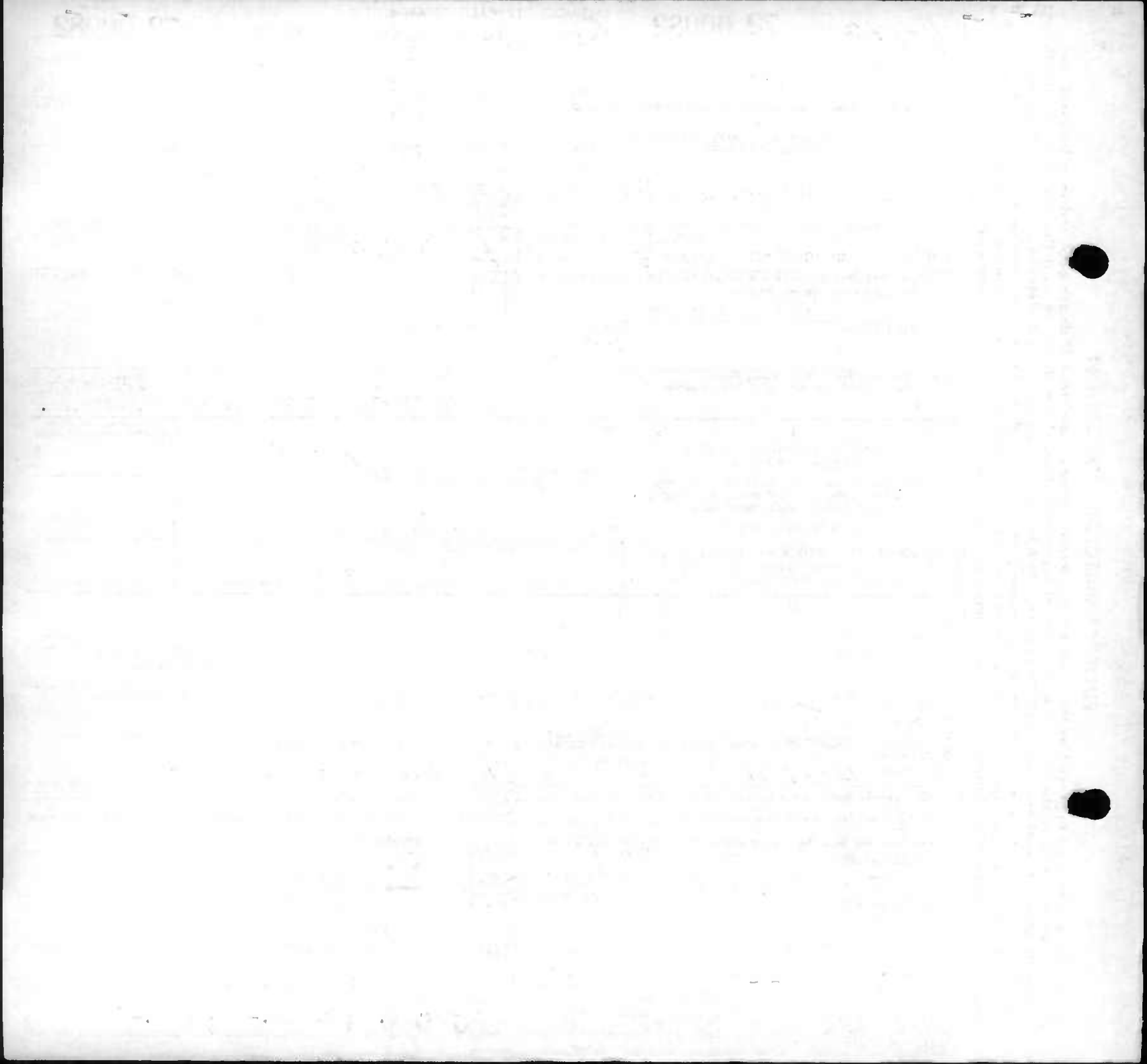
1800 57



Released to Hosp. on approval by M.E. Dr. Cantlon 1/3/71 435  
 FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-142		72 00082		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00082	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) JOHN LIVOLSI				2. DATE AND HOUR OF DEATH 1-3-72 2 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE MARYLAND		B. COUNTY BALTIMORE 907	
4. UNION MEMORIAL HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1529 CARSWELL STREET			
5. SEX Male	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-38	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY tailor		11. BIRTHPLACE (State or foreign country) EUROPE ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN Livolsi				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 2-13 05 8453		17. INFORMANT Angelo Livolsi 1529 Carswell St, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) <del>old age</del> <del>dehydration</del> Fx (R) Hip			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ?			
21D. TIME OF INJURY (APPROX.) 12-27-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell while working			
22. I certify that (I) (this hospital) attended the deceased from 12-30-71 to 1-3-72 and that (I) (we) last saw the deceased alive on 1-3-72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. J. Helou, M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) A. J. HELOU, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 1-6-72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1972		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR Ruck, Inc.		ADDRESS -Balto, Md.-11	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 11 72 00083	
L-520 72 00083					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>William George Link Link</b>			2. DATE AND HOUR OF DEATH <b>1/4/72 4:25 AM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1902</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 MELCHOR NURSING HOME</b> <b>2327 N. Charles St.</b>			C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>			6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>3-13-95</b>			9. AGE (In years last birthday) <b>76 (76)</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S. Md.</b>
13. FATHER'S NAME <b>Frederick William Link</b> <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>Carolyn Schone</b> <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>212-09-6396</b>		17. INFORMANT <b>Edward Link (bro)</b>
18. <b>160.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Ethmoid Sinus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASCVD</b>			CAUSE OF DEATH <b>Carcinoma of Ethmoid Sinus</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>several years</b>
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from <b>Jan. 24</b> 19 <b>70</b> to <b>Jan 4</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>January 3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Ray M. Zimmerman MD</b>			23B. DATE SIGNED <b>Jan. 72</b>		23C. PHYSICIAN'S NAME (Type) <b>Ray M. Zimmerman MD</b>
24A. BURIAL CREMATION REMOVAL (Specify) <b>burial</b>			24B. DATE <b>1-6-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>First Evangelical Lutheran Church Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		
25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Balto, Md.</b>		

1100

WELSH & WELSH  
2127 N. GARDEN ST.

2/20/50

Carroll Square

Frederick Avenue Line

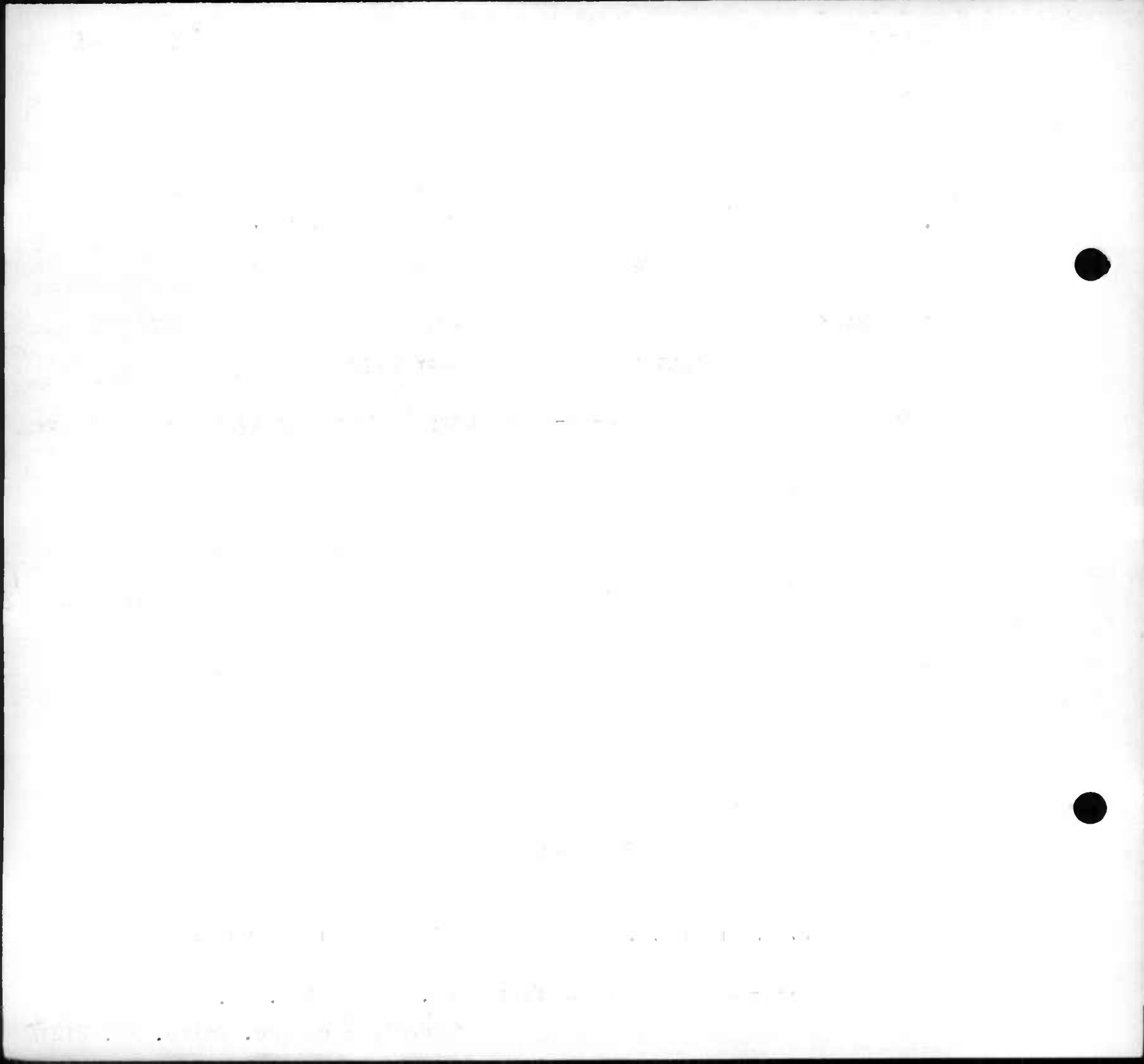
1. Howard (Lumber) 2000 Board Feet

Serial 1-6-75 First International Lumber  
Lumber Company

1000-1000 Lumber

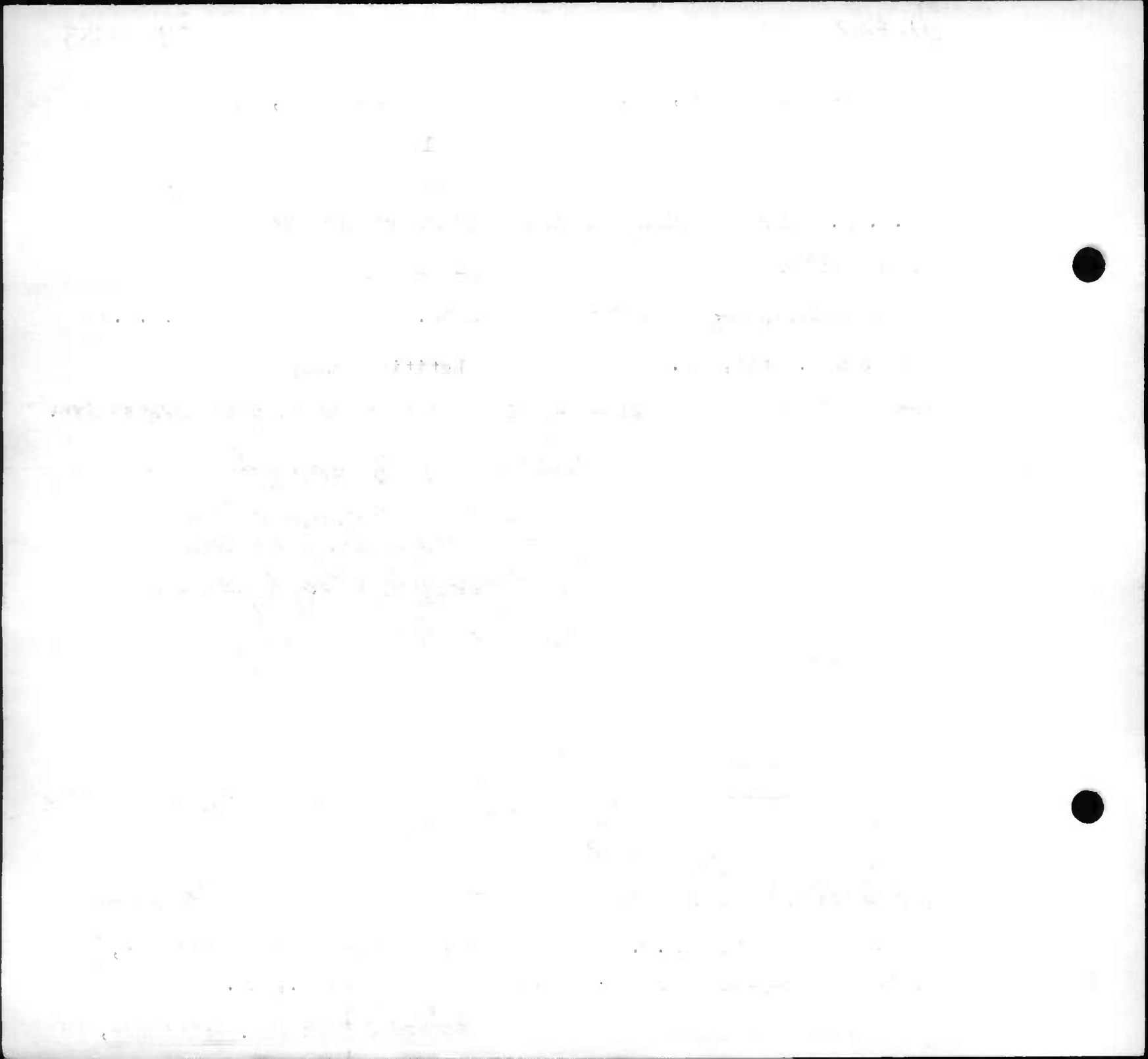
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

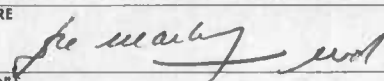
W-300 72 00085		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00085	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Francis H Wait, Jr.</b>			2. DATE AND HOUR OF DEATH <b>January 2, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>D.O. A. Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2744</b>		
5. SEX <b>Male</b>			6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-12-1891</b>			9. AGE (In years last birthday) <b>80</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Francis H. Wait, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Letitia Mundy</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			16. SOCIAL SECURITY NO. <b>216-05-3681A</b>		17. INFORMANT <b>Elizabeth Wait, 5918 Burgess Ave.</b>
18. <b>412-31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Disease - angina pectoris + coronary atherosclerosis</b> <b>Ch Bronchitis + Emphysema</b> <b>gen I arteriosclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1971</b> to <b>Jan 2, 1972</b> that (I) (we) last saw the deceased alive on <b>July 15, 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>Donald W Mintzer M.D.</b>				23B. DATE SIGNED <b>1/3/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald W Mintzer M.D.</b>				23D. ADDRESS <b>3009 Evergreen Ave Baltimore, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

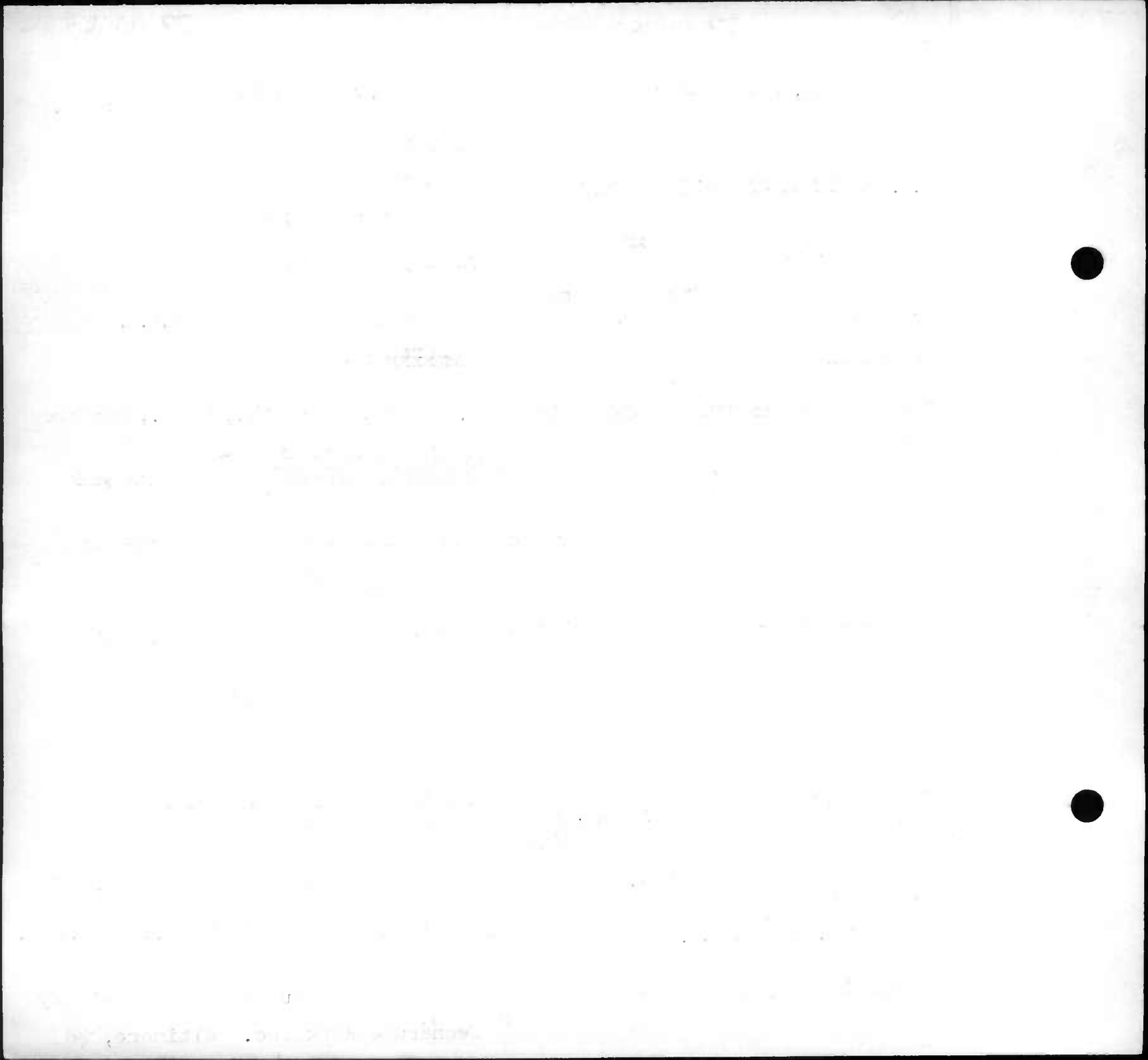
BALTIMORE CITY HEALTH DEPARTMENT				72 00086		72 00086	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>FRANCIS S. BALASSONE, SR.</b>				2. DATE AND HOUR OF DEATH <b>Jan. 2, 1972</b>   <b>11</b> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4323 Glenmore Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2631</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4323 Glenmore Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1915</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Health Protection Director (Dept. Health &amp; Mental Hygn.)</b>				11. BIRTHPLACE (State or foreign country) <b>Thomas, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Balassone</b>				14. MOTHER'S MAIDEN NAME <b>Anna Lacivita</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II USMC</b>		16. SOCIAL SECURITY NO. <b>233-09-1255</b>		17. INFORMANT <b>Dolores Balassone</b>		ADDRESS <b>Same</b>	
18. <b>410-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes.</b>							
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>April 71</b> 19 to <b>Jan 2</b> 1972, that (I) (we) last saw the deceased alive on <b>April 71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED <b>JAN 4/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Jose Martinez, M.D.</b>				23D. ADDRESS <b>Medical Arts Bldg., Balto., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-6-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Bruck, Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Bruck, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

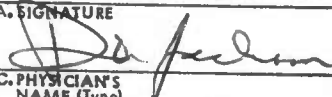
bvs

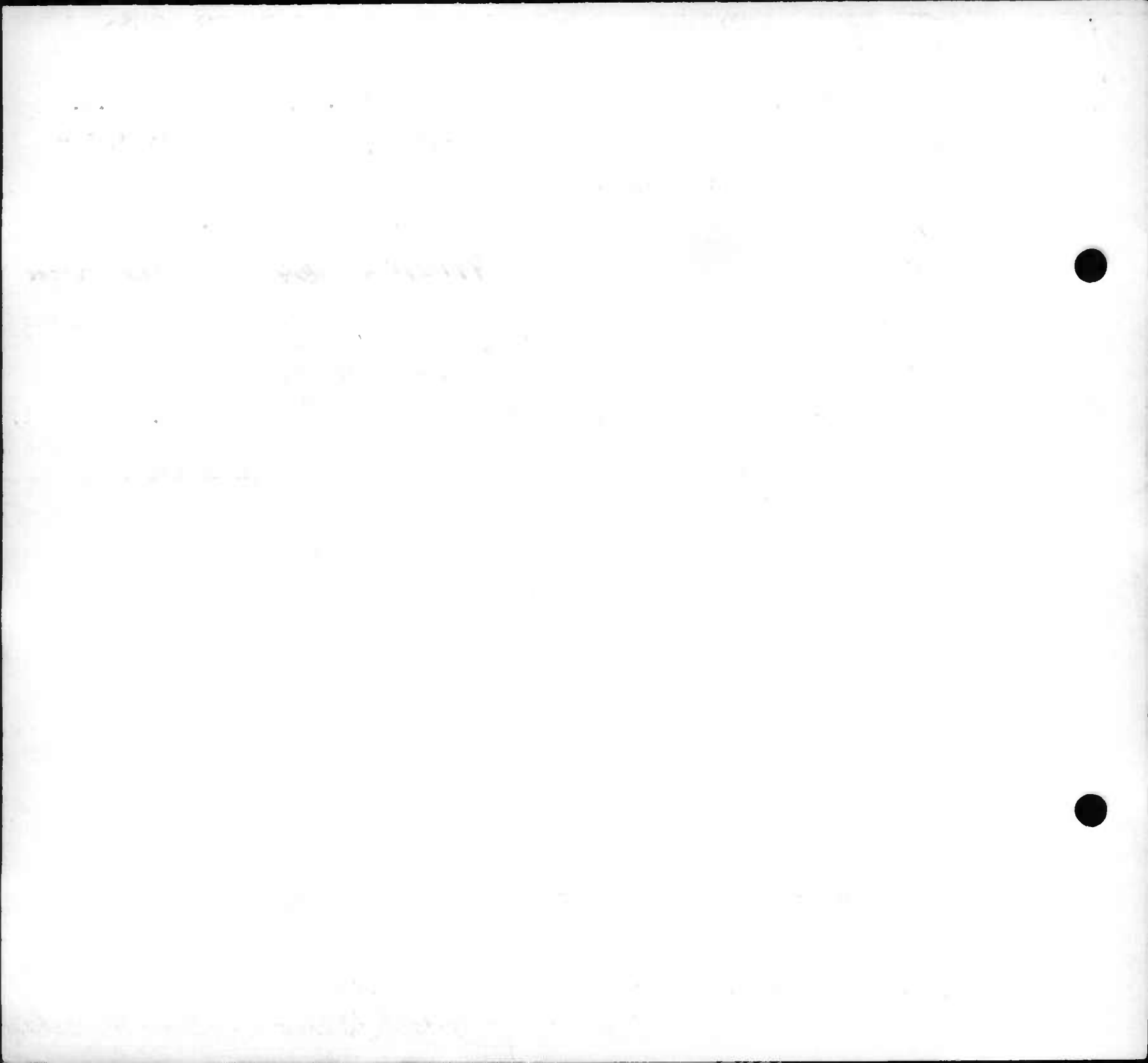
BIRTH NO.		72 00087		BALTIMORE CITY HEALTH DEPARTMENT		72 00087	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Hall, William Coleman</u>				2. DATE AND HOUR OF DEATH <u>January 5, 1972</u> <u>1:45 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Kentucky</u> B. COUNTY <u>V 15</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. PUBLIC HEALTH SERVICE HOSPITAL</u> <u>2X</u>				C. CITY OR TOWN <u>Anchorage</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>9502 Meadowgate Court</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-43</u>	9. AGE in years (last birthday) <u>28</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>The Blue Horse Incorp.</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
13. FATHER'S NAME <u>Roscoe Hall</u>				14. MOTHER'S MAIDEN NAME <u>Lorene Dockrill James</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1966 to 1971</u>				16. SOCIAL SECURITY NO. <u>403 60 4162</u>		17. INFORMANT <u>MED. RECORDS, USPHS HOSP., Balto., Maryland</u>	
18. <u>204.0 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute bilateral broncho-pneumonia with multiple pulmonary infarcts</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>gram negative septicemia</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute lymphocytic leukemia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>one week</u> <u>3 1/2 years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Acute lymphocytic leukemia</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>November 29</u> 19 <u>71</u> to <u>January 5</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>January 4</u> 19 <u>72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert R. Wright, M.D.</u>				23B. DATE SIGNED <u>January 5, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert R. Wright, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Pleasureville</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1972</u>				25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore, Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-623		72 00088		BALTIMORE CITY HEALTH DEPARTMENT		72 00088	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Trusty, Edward</b>				2. DATE AND HOUR OF DEATH <b>Jan. 3, 1972</b>   <b>3 P.M.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Good Samaritan Hospital</b> <b>45</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland,</b> B. COUNTY <b>2739</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1347 Silver Throne Rd.</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/03</b>		9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packing House</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Enos Trusty</b>			14. MOTHER'S MAIDEN NAME <b>Alice Trusty</b>		17. INFORMANT <b>Helen Trusty</b> ADDRESS <b>1705 N. Chapel St.</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 15 days</b>		16. SOCIAL SECURITY NO. <b>218-10-1122</b>					
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Staphylococcus pneumonia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Epidermoid Ca of lung</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) <b>David Jackson</b>				23B. DATE SIGNED <b>1/3/72</b>		23D. ADDRESS <b>Good Samaritan Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/7/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus mem. Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Pk</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>James E. Jackson</b>		25C. FUNERAL DIRECTOR <b>James E. Jackson</b>		ADDRESS <b>1304 N. Central Ave</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00089

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Elvie Young</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>4</b> Year <b>72</b> Hour <b>2:45 A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1439 E. Eager Street</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>4</b> Year <b>72</b> Hour <b>2:45 A. M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1002</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>9/22/94</b>		10. AGE (In years last birthday) <b>77</b>	11. BIRTHPLACE (State or foreign country) <b>Pa</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John Young</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		15. MOTHER'S MAIDEN NAME <b>Betsy Cooper</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-10-3852</b>	
18. INFORMANT <b>Eric Young Jr. 11/147 179 St All-ans. N.Y.</b>		ADDRESS	
19. CAUSE OF DEATH <b>412.41</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/8/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>D. C. County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Young, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph G. Locks Jr.</b>		ADDRESS <b>1304 N. Central Bk</b>	

25 10/19/94

UNITED STATES DISTRICT COURT

1994

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "WHEREAS" and "AND" are faintly visible.]*



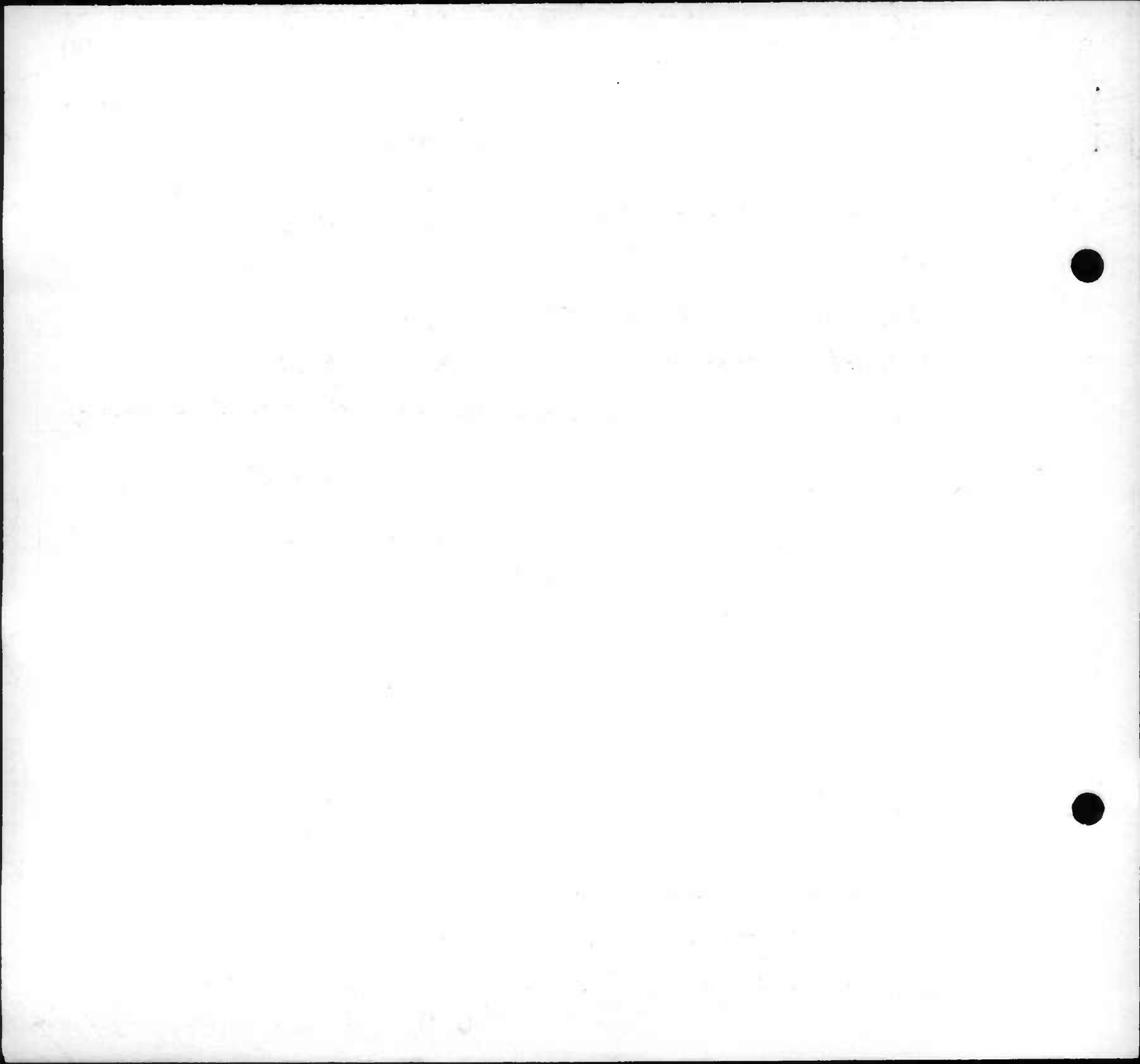


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Hill, Willie  
18 02 99

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00090	
1. NAME OF DECEASED (Type or Print) HILL, Willie		2. DATE AND HOUR OF DEATH 1/5/72 3:47 a. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 807 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1428 N. Broadway			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/03/03	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nathaniel Cousins				14. MOTHER'S MAIDEN NAME Fannie Hill			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-03-1941		17. INFORMANT ADDRESS Margaret Hill 1428 N. Broadway			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ositnenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? (A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Old & Recent CVA DUE TO, OR AS A CONSEQUENCE OF: (C) HASCVD 45 min 3 days (recent) 20 years 11 years Old CVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
22. I certify that (1) (this hospital) attended the deceased from Jan 5, 1972 to Jan 5, 1972 that (1) (we) lost saw the deceased alive on Jan 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas K. Hodous M.D. DEGREE				23B. DATE SIGNED 1/5/72		23C. PHYSICIAN'S NAME (Type) Thomas K. Hodous, MD DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/8/72		24C. NAME OF CEMETERY OR CREMATORY Arbutus mem. PK	
24D. LOCATION Arbutus Hill				24E. CITY, TOWN OR COUNTY Baltimore		24F. STATE MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1972				25B. NAME OF REGISTRAR J. J. Locks		25C. FUNERAL DIRECTOR J. J. Locks	
25D. ADDRESS 1304 N. Central Ave							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00091</u>	
BIRTH NO. <u>H-235 72 00091</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>GILES HOUSTON</u>			2. DATE AND HOUR OF DEATH <u>1-2-72 6:43 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General</u>			A. STATE <u>MD</u> B. COUNTY <u>2201</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>523 Shapell</u>		
5. SEX <u>m</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1906</u>		9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>cook</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>
12. CITIZEN OF WHAT COUNTRY? <u>va</u>			13. FATHER'S NAME <u>—</u>		
14. MOTHER'S MAIDEN NAME <u>—</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Harry Mintz</u>		
ADDRESS <u>117 W. Borne St.</u>					
18. CAUSE OF DEATH <u>412.41 + 250.9</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>C.V.A</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>A.S.C.V.D. + Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF:		
(C) <u>—</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY (Yes or No) <u>—</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( ) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>12-30-1971</u> to <u>1-2-1972</u> and that (1) (we) last saw the deceased alive on <u>11:45 AM 1-2-1972</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1-2-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>D.S. SAWHNEY</u>				23D. ADDRESS <u>S.B.G.H., 21230.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-7-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>mt Auburn Ct</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore City</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
ADDRESS <u>123 W. Monmouth</u>					

1000 57

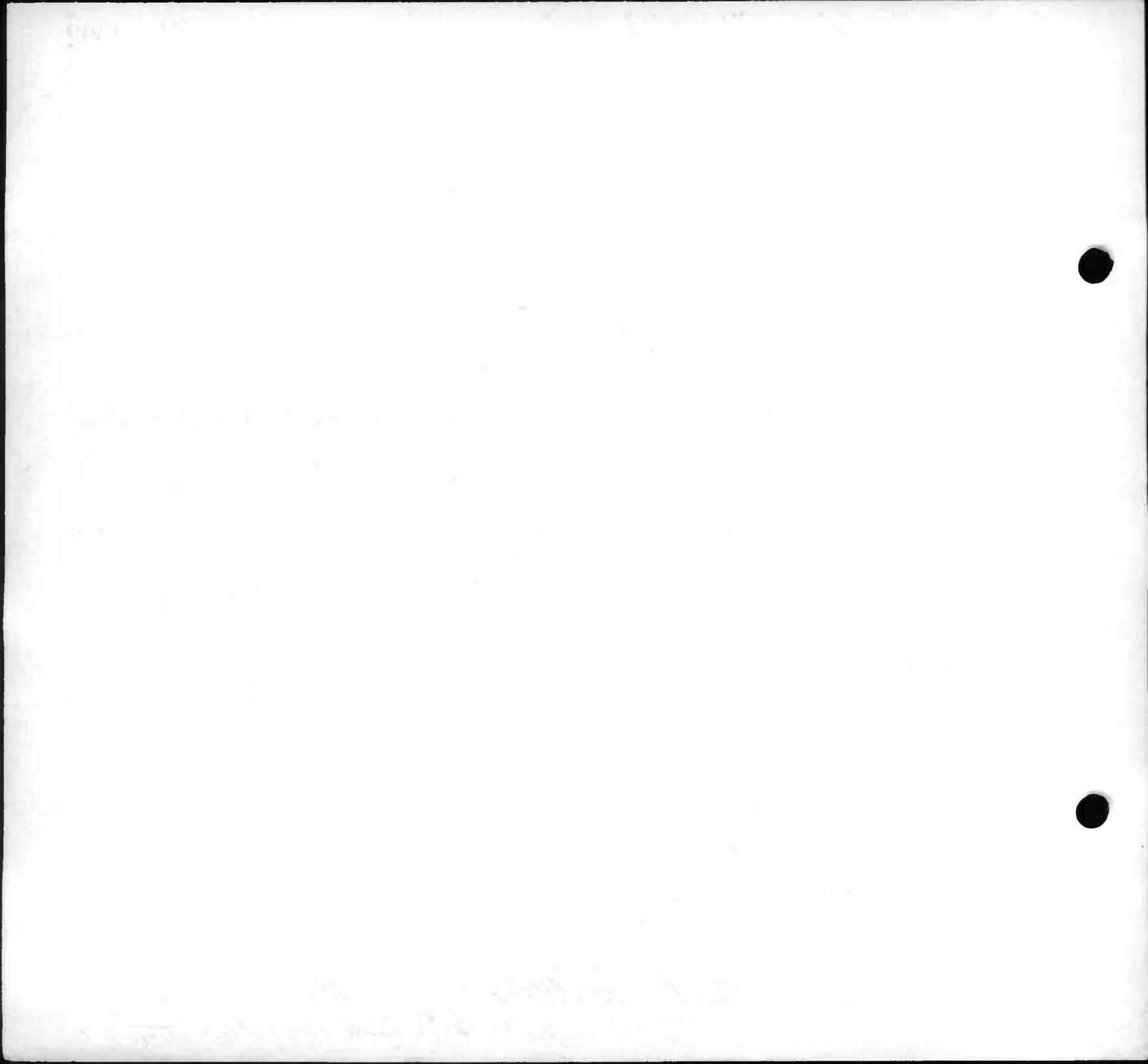
1000 57



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

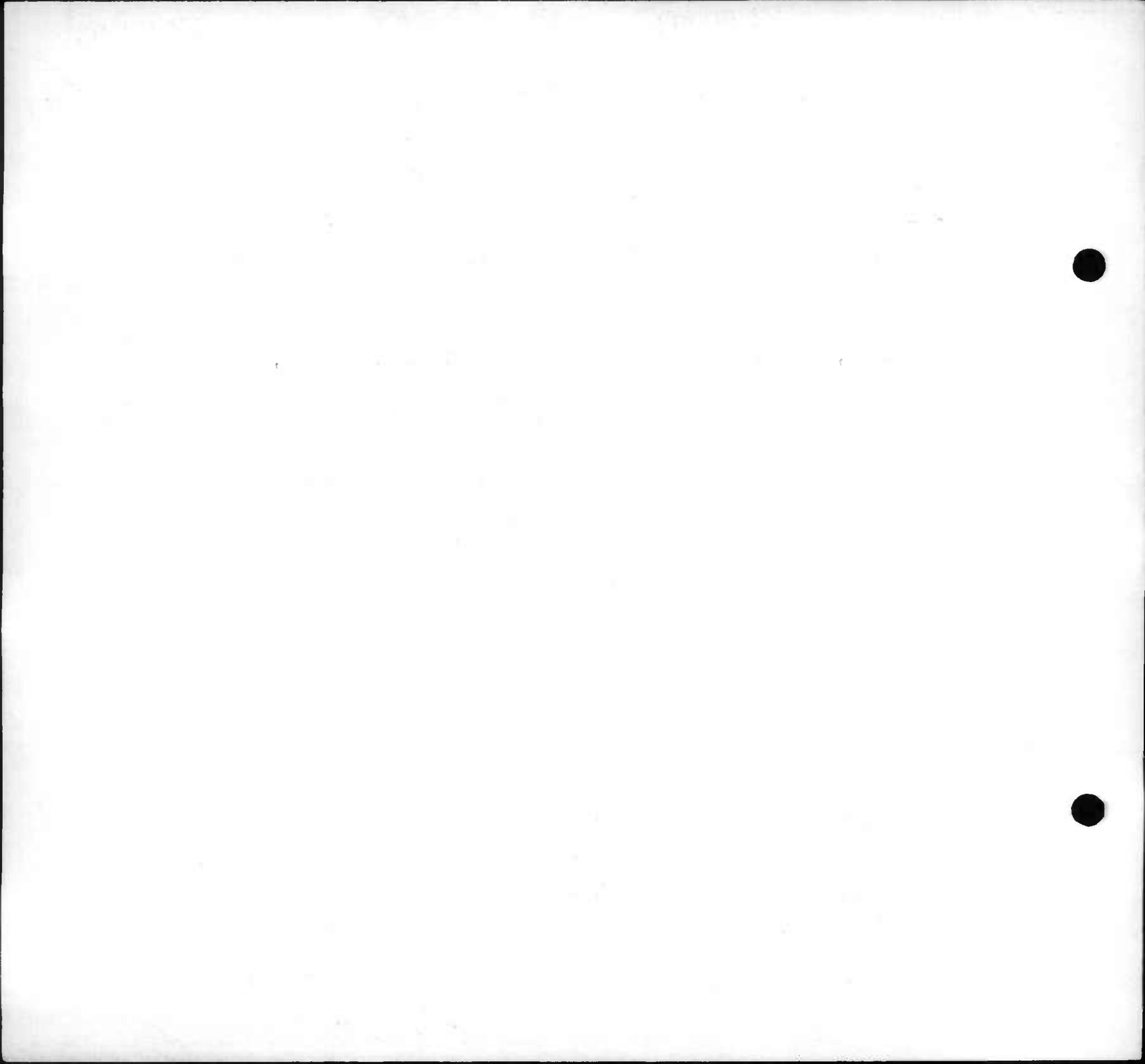
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00092</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>HENRY GILLARD</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>1/2/72 - 10<sup>55</sup> P. M.</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSP</u> <u>43</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2541</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4219 PARKTON ST.</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>COLORED</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-10-07</u>	<b>9. AGE</b> (In years last birthday) <u>64</u>	<b>10. Under 1 Yr.</b> Months: Days: Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>GEORGIA</u>	
<b>13. FATHER'S NAME</b> <u>PAUL GILLARD (DECEASED)</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>OLGA ? (DECEASED)</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>256-28-9616</u>		<b>17. INFORMANT</b> <u>Thomas D. Gillard, Son</u>	
<b>18. <u>403X</u></b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>and uremia.</u>  (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Hypertensive Encephalopathy</u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 yrs.</u>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>NA</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>NA</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <u>NA</u>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NA</u>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>NA</u>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <u>NA</u>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>NA</u>		<b>21F. HOW DID INJURY OCCUR?</b> <u>NA</u>	
<b>22. I certify that (1) (this hospital) attended the deceased from <u>1-25-1971</u> to <u>1-2-1972</u> that (1) (we) last saw the deceased alive on <u>1-2-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>[Signature]</u> <b>23C. PHYSICIAN'S NAME</b> (Type) <u>D. S. SAWHNEY</u>				<b>23B. DATE SIGNED</b> <u>1-2-72</u> <b>23D. ADDRESS</b> <u>4219 Parkton St.</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>1-2-72</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Airy Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) <u>Baltimore</u>		<b>24E. STATE</b> <u>MD</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 6 1972</u>	
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>[Signature]</u> <u>1000 Country Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00093	
G-300 72 00093 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EMMA GOOD</b>		2. DATE AND HOUR OF DEATH <b>1/2/72 3:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>361</b>		
5. SEX <b>FEMALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
8. DATE OF BIRTH <b>6-23-10</b>			9. AGE (In years last birthday) <b>61</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>HODGES, MOSES</b>		
14. MOTHER'S MAIDEN NAME <b>BRANES SMITH, FRANCES</b>			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-22-2164</b>			17. INFORMANT <b>Joseph Good</b> ADDRESS <b>Same</b>		
18. <b>41019 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b> (B) <b>ASCUD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 1</b> 19 <b>72</b> to <b>JAN 2</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>JANUARY 2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael Allen Moore MD</b>			23B. DATE SIGNED <b>7/2/72</b>		23C. PHYSICIAN'S NAME (Type) <b>MICHAEL ALLEN MOORE</b>
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1-5-72</b>			24C. NAME OF CEMETERY or CREMATORY <b>Mt. Lebanon Cent</b>		
24D. LOCATION (City, town, or county) (State) <b>D.C. County</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		
25B. NAME OF REGISTRAR <b>Robert C. Jones, Jr.</b>			25C. FUNERAL DIRECTOR <b>Corbison 1077</b>		
ADDRESS <b>Buamty, Wc</b>					

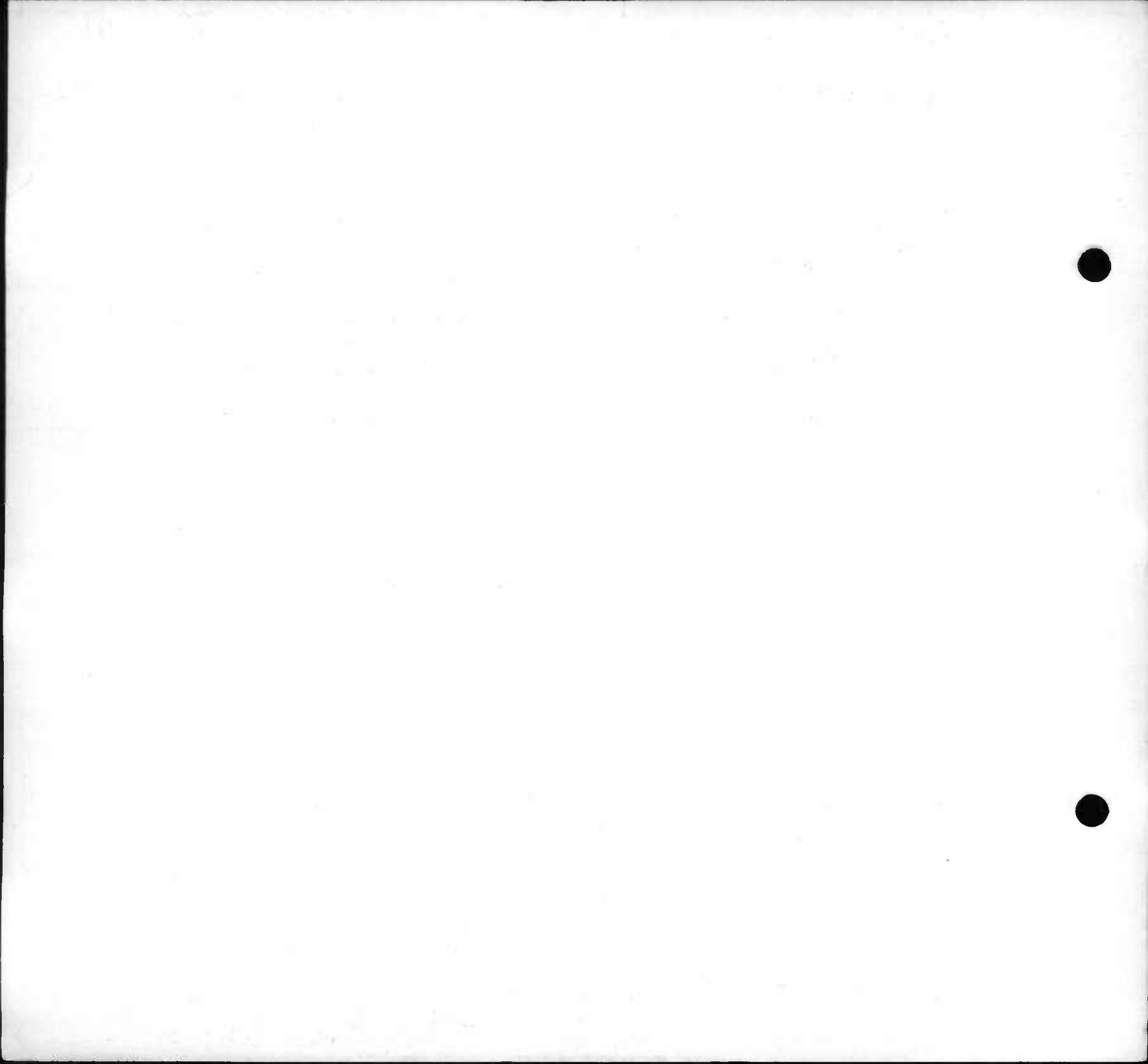




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.2em;">72 00094</span>	
BIRTH NO. <span style="font-size: 1.2em;">L-200</span>		72 00094			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">CANNIE CAMAY LEWIS</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4 25 AM 11-4-72</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1205</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">33</span> <span style="font-size: 1.2em;">The Johns Hopkins Hospital</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">1808 Greenmount Avenue</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/20/17</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">54</span>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">unknown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Berne Ragland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U-S-A</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">William Lewis Same</span>	
18. <span style="font-size: 1.2em;">43601</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CARDIAC ARREST.</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Cerebrovascular Accident</span> <span style="font-size: 1.2em;">Hypertension</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/31</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">1/4</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/4</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">YOSHIZUMI MD.</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">1/4/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MARC O. YOSHIZUMI</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			24B. DATE <span style="font-size: 1.2em;">1-7-72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Inglewood Cent</span>
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore</span>			25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 6 1972</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">P. E. ...</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Connelson or Brantley</span>		



7-622

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
1. NAME OF DECEASED (Type or Print) ALBERT L. FERGUSON		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 3 1972 1:25a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2405 Garrison Blvd.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1538	
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH July 4 - 1938		10. AGE (In years last birthday) 41	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	E. STREET AND NUMBER 2405 Garrison Blvd.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME Clarence C. Ferguson Sr.
15. MOTHER'S MAIDEN NAME Georgie E. Owens		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	17. SOCIAL SECURITY NO.
18. INFORMANT Clarence C. Ferguson Sr.		ADDRESS	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 22		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-3-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-7-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Airy Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR E. J. Wilson 1000 Brantley St.		ADDRESS	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>V-525 72 00096</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>72 00096</u>	
1. NAME OF DECEASED (Type or Print) <u>VINCENT, BEATRICE</u>			2. DATE AND HOUR OF DEATH <u>1/1/72</u> <u>9:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>33</u> <u>JOHNS HOPKINS</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1002</u>		
FULL NAME OF HOSPITAL OR INSTITUTION  <u>33</u> <u>JOHNS HOPKINS</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>917 SUMMERSET ST.</u>					
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/24</u>	9. AGE (In years last birthday) <u>47</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>GEORGE HOWARD</u>			14. MOTHER'S MAIDEN NAME <u>SUSIE Holloman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>121-19-71</u>		
17. INFORMANT <u>Shirley Jones Jones</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC COMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Possible Halothane toxicity</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hepatic coma</u> (B) <u>(Prob Halothane toxicity) Embolism</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Unnec's embolism</u> (C) <u>Possible Halothane toxicity</u>		
19A. DATE OF OPERATION <u>12/19/71</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Appendicitis</u>		
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>12/28/71</u> to <u>1/1/72</u> and that (I) (we) last saw the deceased alive on <u>1/1/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William E. Mitch Jr. MD</u>			23B. DATE SIGNED <u>1/1/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>William E. Mitch Jr. MD</u>			23D. ADDRESS <u>Baltimore, Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-5-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 6 1972</u>		25B. NAME OF REGISTRAR <u>John E. Smith</u>	
25C. FUNERAL DIRECTOR <u>Ordisson on Brantley Jr.</u>		ADDRESS <u>Baltimore, Md</u>			

917 SOMERSET ST

B-635 72 00097

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00097

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John Britton</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 1 72 3:01 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 3:01A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>August 21-10</b>				10. AGE (in years last birthday) 61		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Steven Britton</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				15. MOTHER'S MAIDEN NAME <b>Alice</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO. <b>248-10-8531</b>		18. INFORMANT <b>Sue Britton</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
20A. DATE OF OPERATION <b>8</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-2-72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-10-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crown Mt</b>		24D. LOCATION (City, town, or county) (State) <b>Lanham Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Edwin W. Brantley</b>		ADDRESS	

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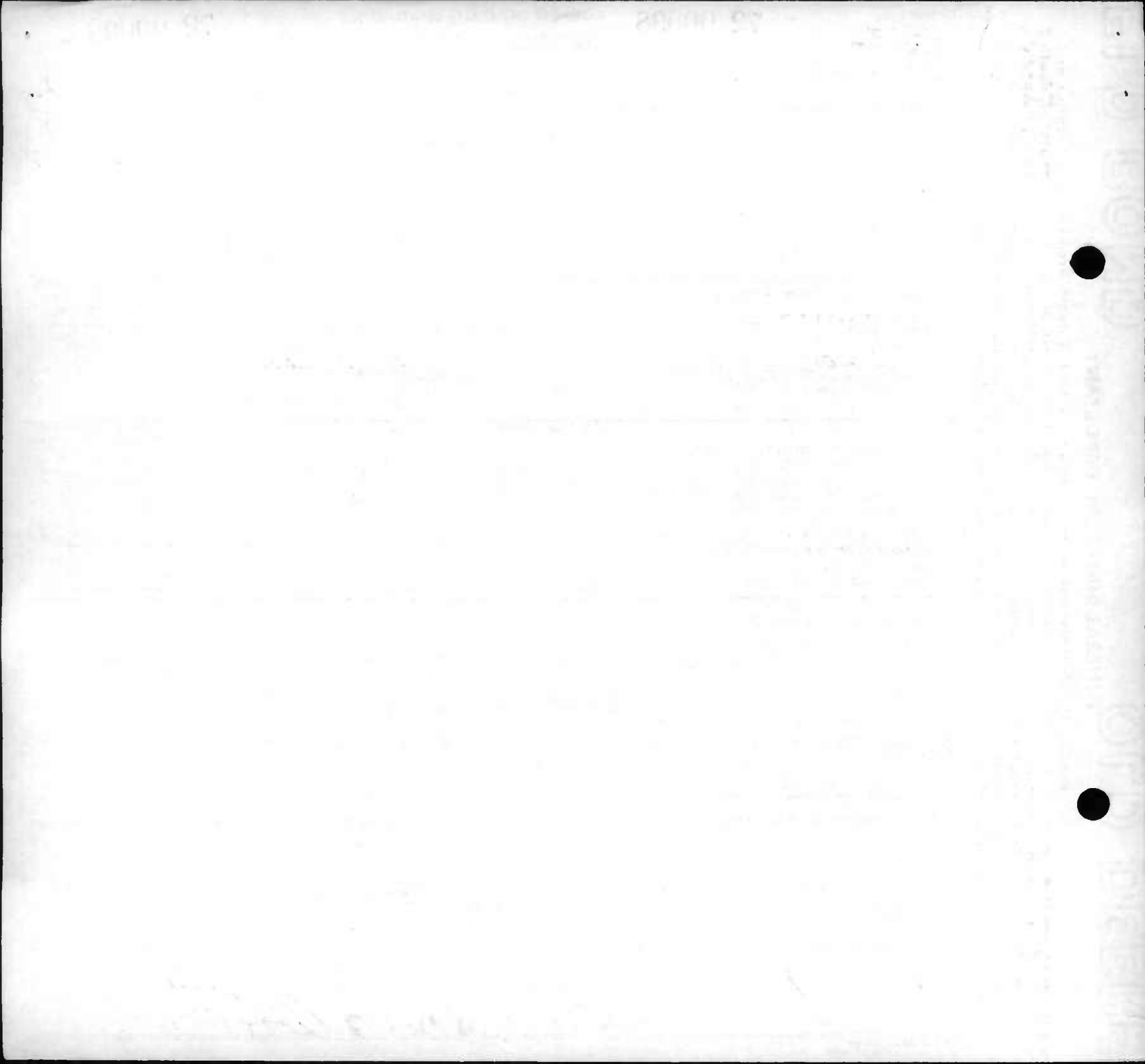




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-236		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00098	
72 00098			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>John Feaster</u>			2. DATE AND HOUR OF DEATH <u>DoA - 6:20 PM Jan. 2, 1972</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hosp.</u> <u>+ 4 Balto., Md. 21218</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>907</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1549 E. Carswell St.</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/21</u>	9. AGE (in years, last birthday) <u>50</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Lawson Feaster</u>			14. MOTHER'S MAIDEN NAME <u>Mary McKirney</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWII</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Stepdaughter + wife</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Tuberculosis</u> I <u>01/19/72</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Tuberculosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II <u>H.B.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John Graber, M.D.</u> DEGREE				23B. DATE SIGNED <u>Jan. 2, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>John D. Graber</u> DEGREE				23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-7-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Not before Cert</u>	
24D. LOCATION <u>Balto</u>		24E. CITY, TOWN, OR COUNTY <u>MD</u>		24F. STATE <u>MD</u>	
25A. DATE RECD BY HEALTH DEPT. <u>JAN 6 1972</u>		25B. NAME OF REGISTRAR <u>John D. Graber</u>		25C. FUNERAL DIRECTOR <u>E. O. Wilson</u>	
25D. ADDRESS					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00099</span>	
D-525 72 00099				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Dinkins, ROSIE M.</i>		2. DATE AND HOUR OF DEATH <i>1-3-1972 4-45 p.m.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1608</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>LUTHERAN HOSPITAL OF MARYLAND</i> <i>46</i>		C. CITY OR TOWN <i>BALTIMORE, MD</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>703 GRANTLEY ST</i>		8. DATE OF BIRTH <i>8-31-09</i>		9. AGE (In years last birthday) <i>62</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY
13. FATHER'S NAME <i>Clark Pennell</i>		14. MOTHER'S MAIDEN NAME <i>Georgie Johnson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-24-9019</i>		17. INFORMANT <i>Husband Julian T.</i>	
18. <i>1890 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Secondaries in Liver</i> <i>Carcinoma Kidney</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>12/16/71</i> 19 <i>71</i> to <i>1/3/72</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>1-3-</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D.S. Karbhari</i> M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1-3-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>D.S. KARBHARI</i>		23D. ADDRESS <i>Lutheran Hospital.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-8-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 6 1972</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.A.</i>		25C. FUNERAL DIRECTOR <i>Marshall W. Jones, Jr.</i>			

Secondary in  
Carcinoma Kidney

no

Dr KARAGIARI  
M.D.

Examination of

D-300

72 00100

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00100

BIRTH NO.

REG. NO.

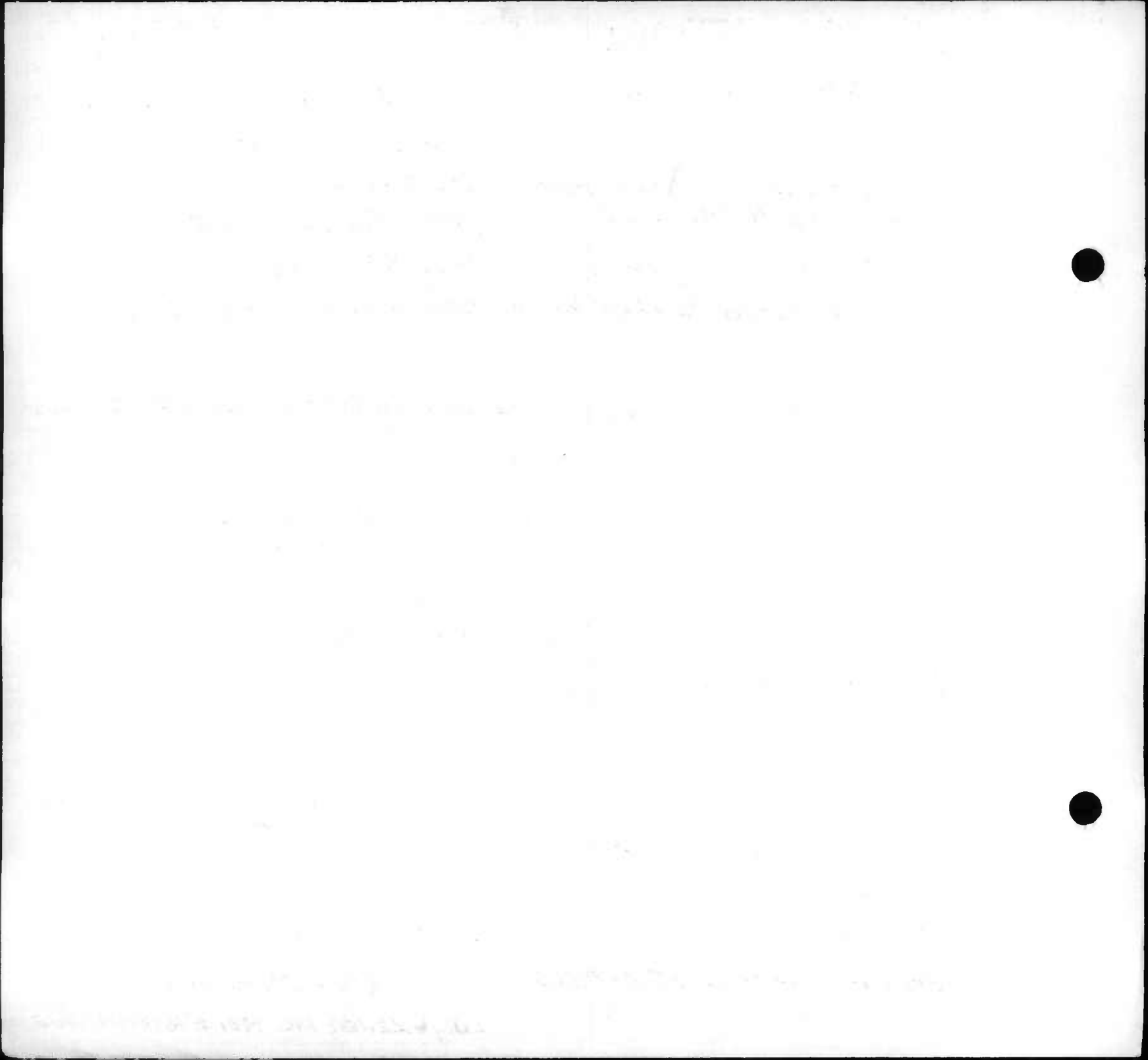
1. NAME OF DECEASED (Type or Print) John Duda				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 4 Year 72 Hour 1:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 229 S. Ann Street				3. DATE PRONOUNCED DEAD Month 1 Day 4 Year 72 Hour 1:20 P. M.	
6. SEX Male				7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-9-1899				10. AGE (in years last birthday) 72	
11. BIRTHPLACE (State or foreign country) UKRAINE				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				14. KIND OF BUSINESS OR INDUSTRY FARMER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-30-2383	
17. INFORMANT ALEXANDER DUDA 2110 E. PRATT ST				18. ADDRESS 2110 E. PRATT ST	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:	
22A. DATE OF OPERATION				22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22H. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 1-4-72					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-8-72		24C. NAME OF CEMETERY or CREMATORY ST. MICHAELS UKRAINIAN	
24D. LOCATION (City, town, or county) (State) BALTO. Co. Md		24E. DATE REC'D BY HEALTH DEPT. JAN 6 1972			
24F. NAME OF REGISTRAR JAN 6 1972		24G. NAME OF REGISTRAR JAN 6 1972		24H. FUNERAL DIRECTOR L. H. ZIEGLER INC. 1901 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00101	
C-252 72 00101				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY C. COUSINS</u>		2. DATE AND HOUR OF DEATH <u>1-4-72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 CENTURY NURSING HOME</u> <u>102 N. PACA ST.</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>201</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BAITIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-26-87</u>		9. AGE (In years last birthday) <u>84</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SON LIFE INS. CO</u>		11. BIRTHPLACE (State or foreign country) <u>PATERSON, NEW JERSEY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-8122</u>		17. INFORMANT <u>BERNARD LUMSDEN 2612 FOSTER AVE</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary Embolism &amp; Infection</u> <u>Arteriosclerotic C.U.H.D.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic C.U.H.D.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic C.U.H.D.</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic C.U.H.D.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Amputation @ leg.</u>		19A. DATE OF OPERATION <u>Dec 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Arteriosclerosis</u>	
20A. AUTOPSY? (Yes or No) <u>N/O</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>INJURY OCCUR?</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>APPROX</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21E. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>Dec 24</u> 19 <u>71</u> to <u>Jan 4</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan 4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.	
23A. SIGNATURE <u>William D. Appleberry</u> DEGREE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>William D. Appleberry</u> DEGREE	
23D. ADDRESS <u>6615 Rustenstown Rd</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-7-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>ST. MATTHEWS</u>		24D. LOCATION (City, town, or county) (State) <u>6104 O'DONNELL ST</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1972</u>	
25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>LD 141-21102 INC. 1901 EASTERN AVE</u>		25D. ADDRESS	





BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES( BRISTOL) Michael</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1108 W. Mosher St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 2 1972 9:45a</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1601</b>	
9. DATE OF BIRTH <b>1/19/</b>		10. AGE (in years lost birthday) <b>56</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Dozier Michael</b>		14. STREET AND NUMBER <b>1108 W. Mosher St.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Peggy</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs Bristol, 910 N Fremont Ave</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-3-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/6/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT Calvary Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>Halstead</b>	
25C. FUNERAL DIRECTOR <b>Halstead</b>		ADDRESS <b>1206 W North Ave</b>	



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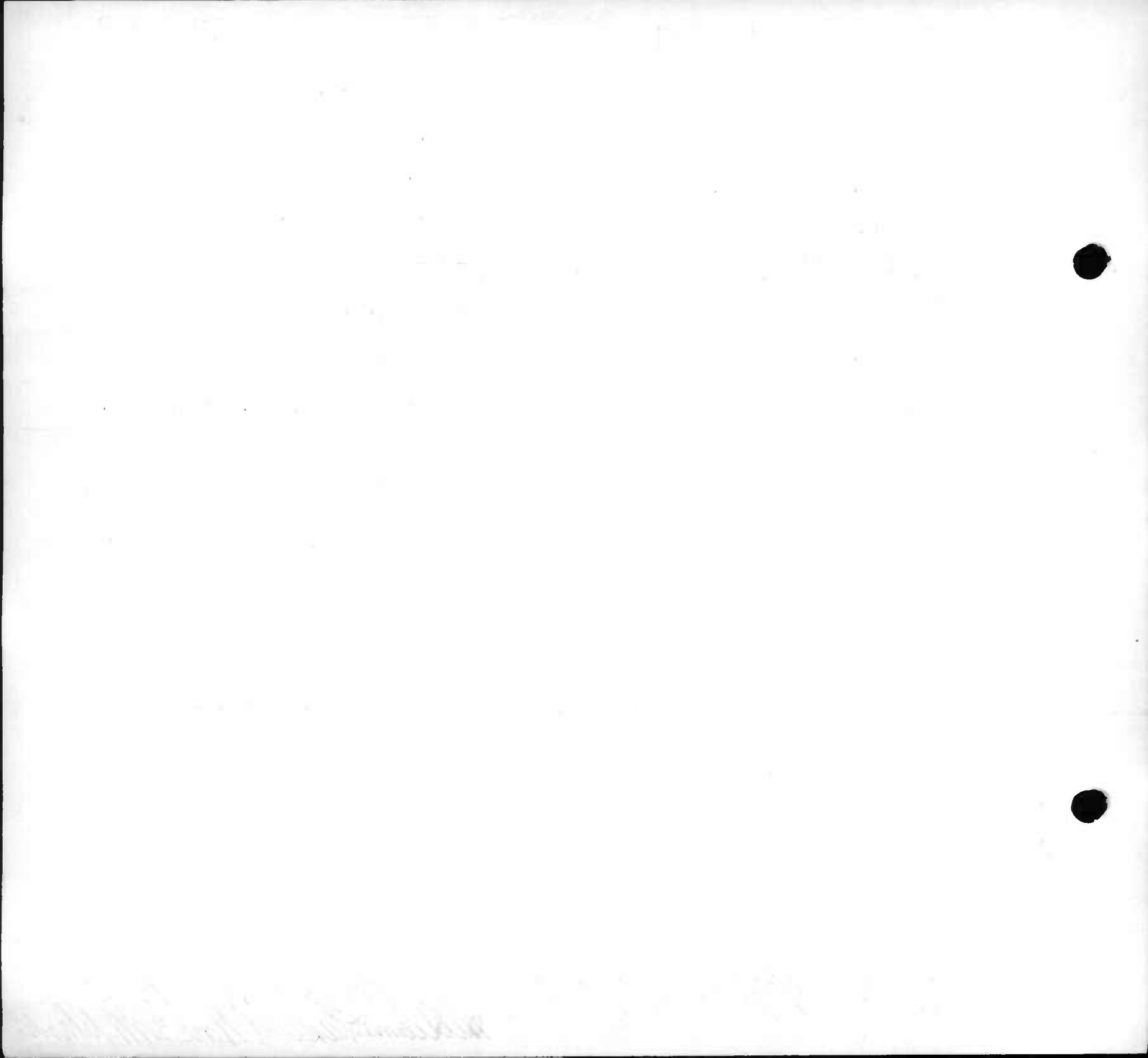
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-535 72 00103		BALTIMORE CITY HEALTH DEPARTMENT		72 00103	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Sallie Anthoney</b>			2. DATE AND HOUR OF DEATH <b>Jan. 1, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>18 N. Morley St.</b>			A. STATE <b>Md.</b> B. COUNTY <b>2047</b>		
			C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>18 N. Morley St.</b>		
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1889</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Shannon N.C.</b>	
13. FATHER'S NAME <b>John H. Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Mary McCollum</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>William Murphy 18 N. Morley St.</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardio Renal Disease</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Occlusion</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Day</b>
			(B) <b>Cardio Renal Disease</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>Unknown</b>
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-15-1970</b> to <b>1-2-1972</b> that (I) (we) last saw the deceased alive on <b>12-2-1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard H. Hunt</b>			23B. DATE SIGNED <b>1-3-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Richard H. Hunt</b>			23D. ADDRESS <b>160710. Mulberry St - Balt. Md 21223</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Prospect Cem. Prospect, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Md. 000</b>		25C. FUNERAL DIRECTOR <b>William M. Funeral Home 3198. Whitcomb</b>	



A-536

72 00104

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00104

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN ANDERSON

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 204 N. Arlington Ave.

3. DATE PRONOUNCED DEAD Month Day Year Hour  
1 3 1972 10:30a M.5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)  
A. STATE B. COUNTY

Md.

1802

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 30, 1894

10. AGE (In years last birthday)

77 75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

204 N. Arlington Ave.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Anderson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

retired

15. MOTHER'S MAIDEN NAME

Martha Wormley

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes No W.W.I.

17. SOCIAL SECURITY NO.

212-76-5949A

18. INFORMANT

John W. Anderson

ADDRESS

Phila. Pa.

19. 412.41

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-3-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/6/1972

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Cider Hill Md.

(State)

25A. DATE REC'D BY HEALTH DEPT

JAN 6 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

317 N. Lombard St.

100000

100000

Yes W.W.I. - 100000  
John W. W. I. - 100000  
John W. W. I. - 100000

100000 - 100000  
100000 - 100000  
100000 - 100000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>M-620 72 00105</i>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>72 00105</i>	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>AUGUST P. MEYERS</b>				2. DATE AND HOUR OF DEATH <b>JAN. 2, 1972</b> <b>8:35 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Lake Drive Nursing Home</b> <b>2401 Eutaw Place</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>602</b> C. CITY OR TOWN <b>Baltimore 21224</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>230 North Milton Avenue</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 19, 1905</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>August Meyers</b>				14. MOTHER'S MAIDEN NAME <b>Rose Gorericke</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 05 5021</b>		17. INFORMANT <b>Mrs Margaret C. Meyers</b> ADDRESS <b>230 North Milton Ave.</b>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest -</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute myocardial infarction</b> <b>ASCVD + PEPTIC 2 Abdominal pain + Aphasia</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/21/69</b> 19 to <b>1/2/72</b> 19, that (I) (we) last saw the deceased alive on <b>1-30</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Arce</i> <b>MO</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/4/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARCELINO ALBUERNE M.D.</b>				23D. ADDRESS <b>8228 Smallwood Road Balto. Md. 21226</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/5/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS INC. BALTIMORE MARYLAND 21213</b>			



USA

Officially recognized

Government

United States

Department of State

Office of the Secretary

Washington

EX-111

10/1/72

AMERICAN AIRLINES, INC. - 1000 International Place - New York, N.Y.

Donald W. Davis, President

1000 International Place



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-651

72 00106

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 00106

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

TURNIPSEED, ROBERTA

2. DATE AND HOUR OF DEATH

1/4/72

4:30 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

805 Lyndhurst Street

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

4/12/04

9. AGE (In years  
last birthday)

67

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richland Co, S. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Henry Crosby

14. MOTHER'S MAIDEN NAME

Nona Trapp

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
216-36-6785

17. INFORMANT

ADDRESS

Sonya Turnipseed 805 Lyndhurst St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

ASPIRATION

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DIABETES

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 HR.

MANY YRS.

MANY YRS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3 1972 to 1/4 1971  
that (I) (we) last saw the deceased alive on 1/4 1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stephen Fox MD

Attending ☒  
Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

1/4/72

23C. PHYSICIAN'S  
NAME (Type)

STEPHEN FOX MD

23D. ADDRESS

601 N. BROADWAY

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-8-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 6 1972

25B. NAME OF REGISTRAR

Robert E. Talley, Jr.

25C. FUNERAL DIRECTOR

Morton &amp; Dyett Funeral Home 1701 Laurens St.

ADDRESS

7. 71

77 11

71

27

217

5.

... ..

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES E. ROSS

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BON SECOURS HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

January 4, 1972

7:15 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct 16, 1924

10. AGE (In years  
last birthday) 47If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2017 W. Mulberry Street

11. BIRTHPLACE (State or foreign country)

Mobile, Alabama

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

James Dewey Ross

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Willie Stevens

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

17. SOCIAL  
SECURITY NO.  
212-26-0683

18. INFORMANT

ADDRESS

Mrs. Mable Ross 2017 W. Mulberry St.

19. E 988 X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Intracerebral Hemorrhage-

Contusions and Intracerebral Hematoma

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

Unk.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/5/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-8-72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 6 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Morton &amp; Dyett F. H. 1701 Laurens St.

2-17-1972 - Letter from - Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.  
Assistant Medical Examiner

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		72 00108		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00108	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>James Smith</i>				2. DATE AND HOUR OF DEATH <i>1/2/72</i> <i>8:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i>				A. STATE <i>MARYLAND</i> B. COUNTY <i>1001</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1051 N. CENTRAL AVE.</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-12-16</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>So Brunswick Co, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Richard Smith</i>				14. MOTHER'S MAIDEN NAME <i>Della Haskins</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sidney Haskins</i> ADDRESS <i>2523 Popes Lane</i>		
18. <i>162-1 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Cardio-respiratory Arrest</i> <i>1 1/2 yrs</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Metastatic Ca of Lung</i> <i>1 1/2 yrs</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>12/22</i> 19 <i>71</i> to <i>1/2</i> 19 <i>72</i> that <i>(X)</i> (we) last saw the deceased alive on <i>1/2/72</i> 19 <i>72</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>James Franklin Grim MD</i>				23B. DATE SIGNED <i>1/2/72</i>		23C. PHYSICIAN'S NAME (Type) <i>James Franklin Grim</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-7-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 6 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Baker</i>		25C. FUNERAL DIRECTOR <i>Morton &amp; Dyett F. H.</i>		ADDRESS <i>1701 Laurens St.</i>	



M-254

72 00109 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00109

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) John McMillian		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 4 Year 72 Hour 9:15 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1433 Harford Avenue		3. DATE PRONOUNCED DEAD Month 1 Day 4 Year 72 Hour 9:15 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 909	
9. DATE OF BIRTH 3-13-05		10. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John C. McMillian		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Minder Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 237-28-5401		18. INFORMANT Ella J. McMillian	
19. 577-81 CAUSE OF DEATH		ADDRESS 912 E. 20th St	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Pulmonary emphysema Hypertensive cardiovascular disease	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-4-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-10-72	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1972		25B. NAME OF REGISTRAR Wm C. March	
25C. FUNERAL DIRECTOR 928 E. North Ave.		ADDRESS	

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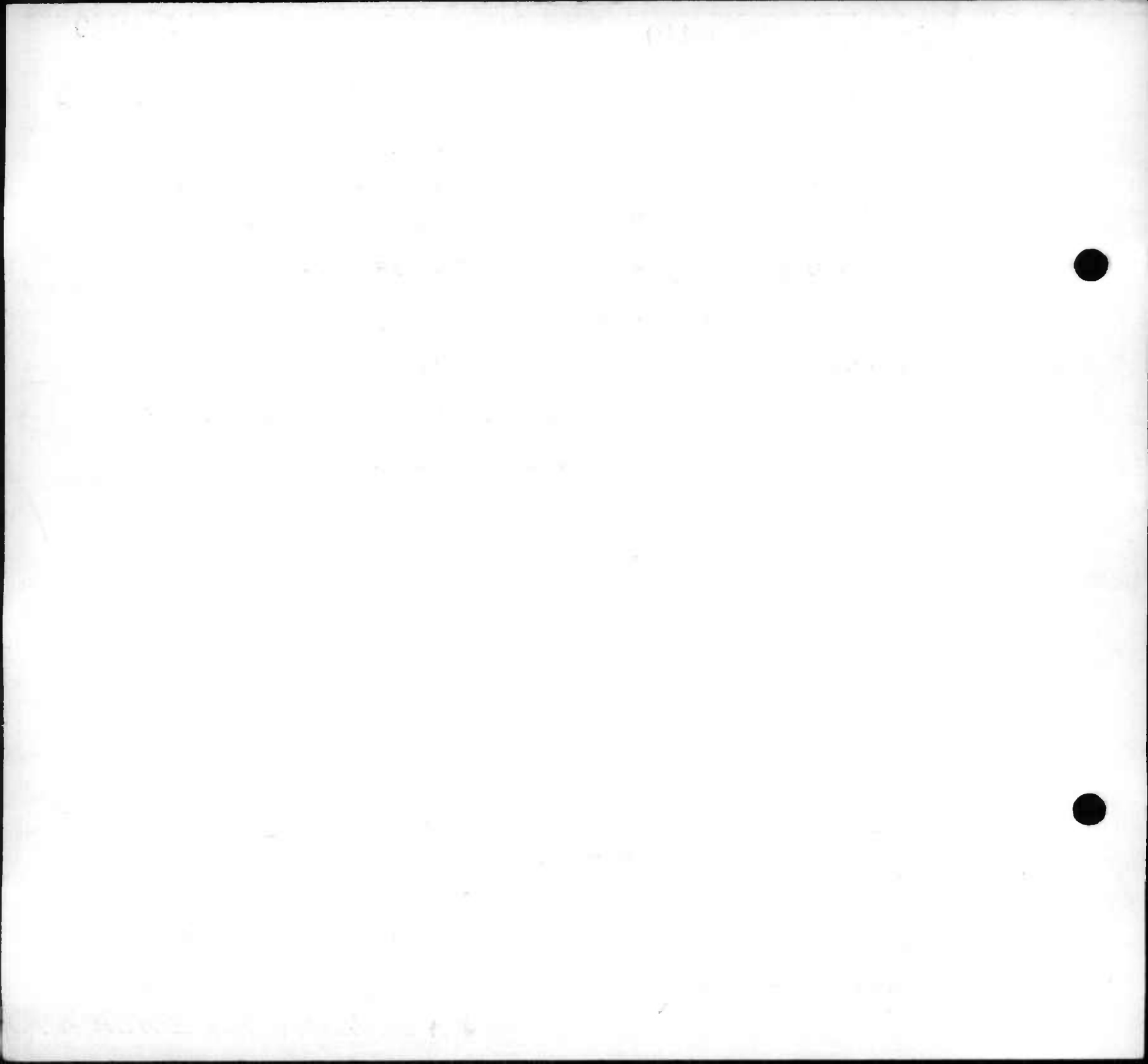




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-525 72 00110		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00110 REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>John Jenkins</u>		2. DATE AND HOUR OF DEATH <u>5 Jan 1972</u> <u>9:05 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>5601 Loch Raven Blvd. Baltimore 21239</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>802</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2420 E Lanvale St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 July 1905</u>	9. AGE (in years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer -</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pipe Mill -</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>422-12-2285</u>		17. INFORMANT <u>George Jenkins</u> ADDRESS <u>2420 E Lanvale St.</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Carcinoma of Lung c Metastases</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25</u> 19 <u>71</u> to <u>5 Jan</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>5 Jan.</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John D. Talbert, M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>John D. Talbert, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-9-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Eutaw, Alabama</u>	
24D. LOCATION (City, town, or county) (State) <u>Eutaw, Alabama</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1972</u>		25B. NAME OF REGISTRAR <u>000</u>	
25C. FUNERAL DIRECTOR <u>WHA</u>		25D. ADDRESS <u>928 E North Ave</u>			



72 00111

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00111

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>L. HERBERT HARRIS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>1 3 1972 2:20 a</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>8-25-22</b>		10. AGE (In years lost birthday) <b>49</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Boger Harris</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2001</b>	
15. MOTHER'S MAIDEN NAME		E. STREET AND NUMBER <b>1922 W. Fayette St.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		17. SOCIAL SECURITY NO. <b>213-14-6313</b>	
18. INFORMANT <b>Melvinia Harris</b>		ADDRESS <b>616 McCabe Ave</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>1-3-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-7-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>John E. Fisher, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Wm C. March</b>		ADDRESS <b>928 E North Ave.</b>	

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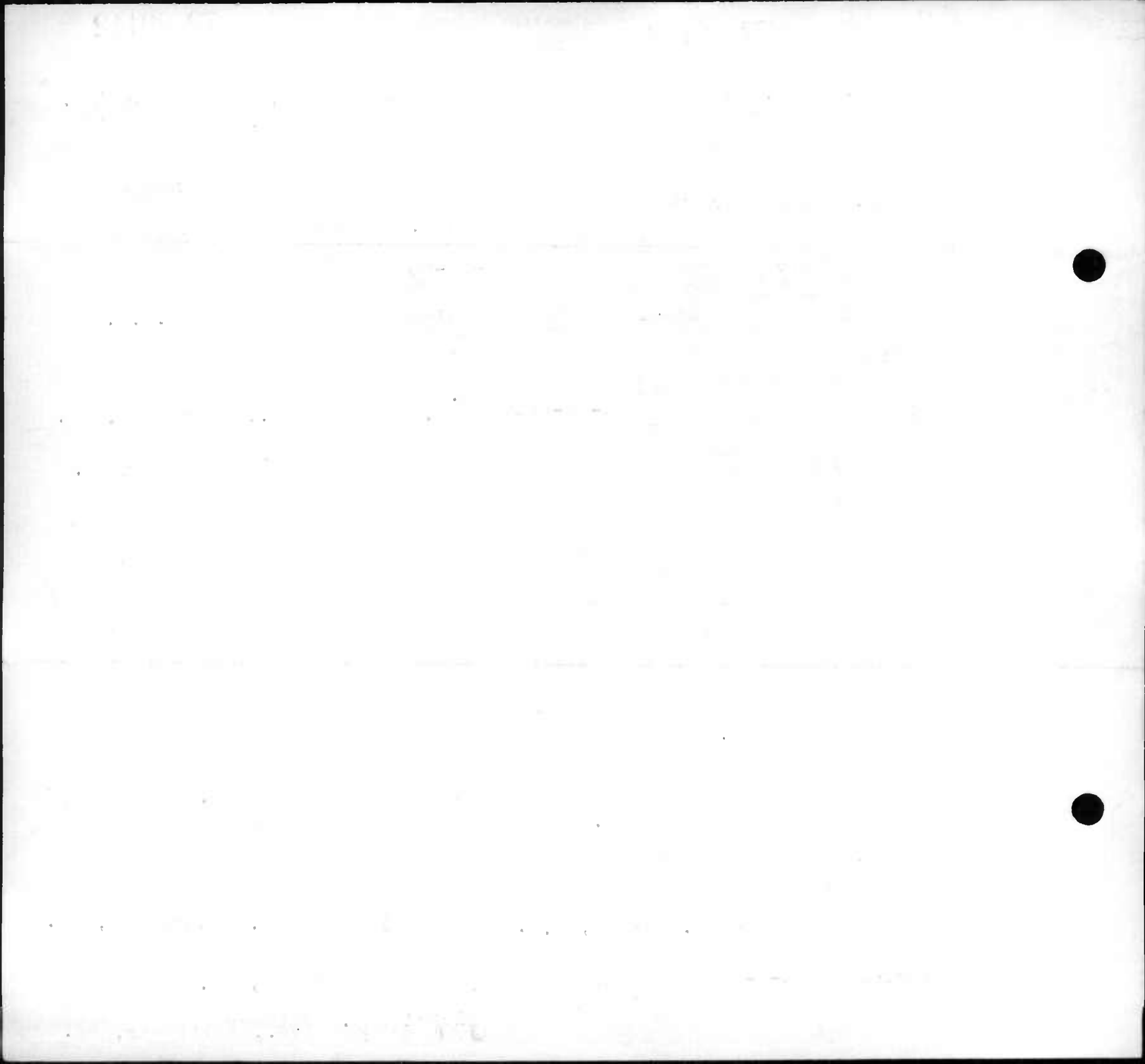
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 00112	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
JOHN L. BLOOM		January 3, 1972		3:30/A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland Baltimore		102	
607 S. Ellwood Avenue		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		607 S. Ellwood Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 To 12 Months
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-28-06	65	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Foreman		Steel		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Milton		Sadie		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216-01-0269		Mrs. Amelia Bloom	
				ADDRESS	
				607 S. Ellwood Ave., Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Bronchogenic Carcinoma		1 yr.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February 19 50 to Jan. 19 72 that (I) (we) last saw the deceased alive on Dec. 27 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Clarence W. LeDoux		1/4/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Clarence W. LeDoux, M.D.		3023 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-6-72		Oak Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 7 1972		Nicholas T. Matthews		ADDRESS	
				3021 Eastern Ave., Baltimore, Md.	



S-552

72 00113

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00113

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank W. Szymanski		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 3 Year 72 Hour 4:19 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month 1 Day 3 Year 72 Hour 4:10 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300	
9. DATE OF BIRTH 12-27-1919		10. AGE (in years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME Edward Szymanski		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman	
15. MOTHER'S MAIDEN NAME Angelene Gusdonski		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes ww 11	
17. SOCIAL SECURITY NO. 213 05 5854		18. INFORMANT ADDRESS Mrs Stella Szymanski 6859 Boston Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-4-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-7-72	
24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR WALTER DABROWSKI	
25C. FUNERAL DIRECTOR WALTER DABROWSKI		ADDRESS 1005 DUNDALK AVENUE	





72 00114

BALTIMORE CITY HEALTH DEPARTMENT

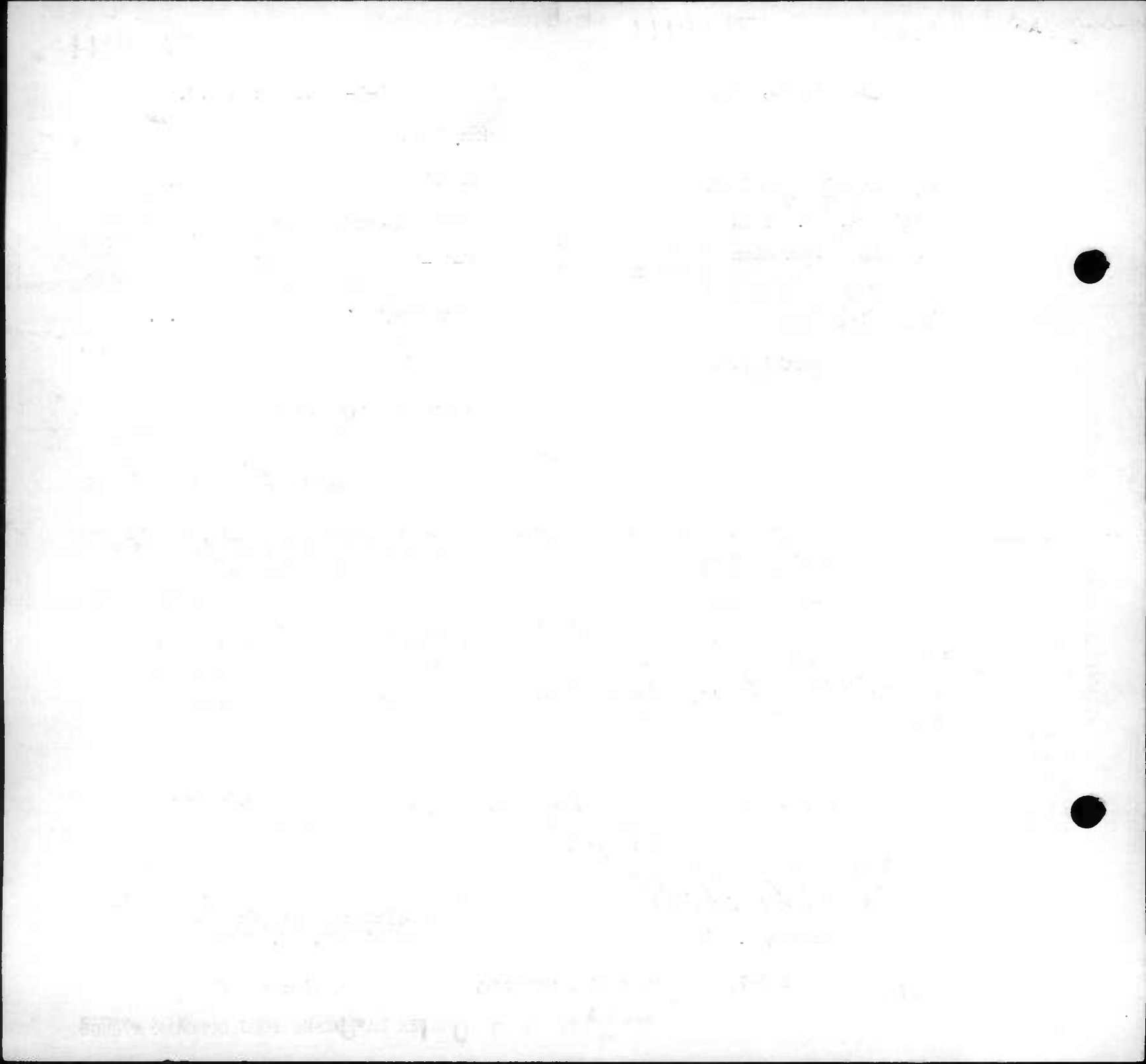
## CERTIFICATE OF DEATH

REG. NO. 72 00114

FUNERAL DIRECTOR: IMPORTANT

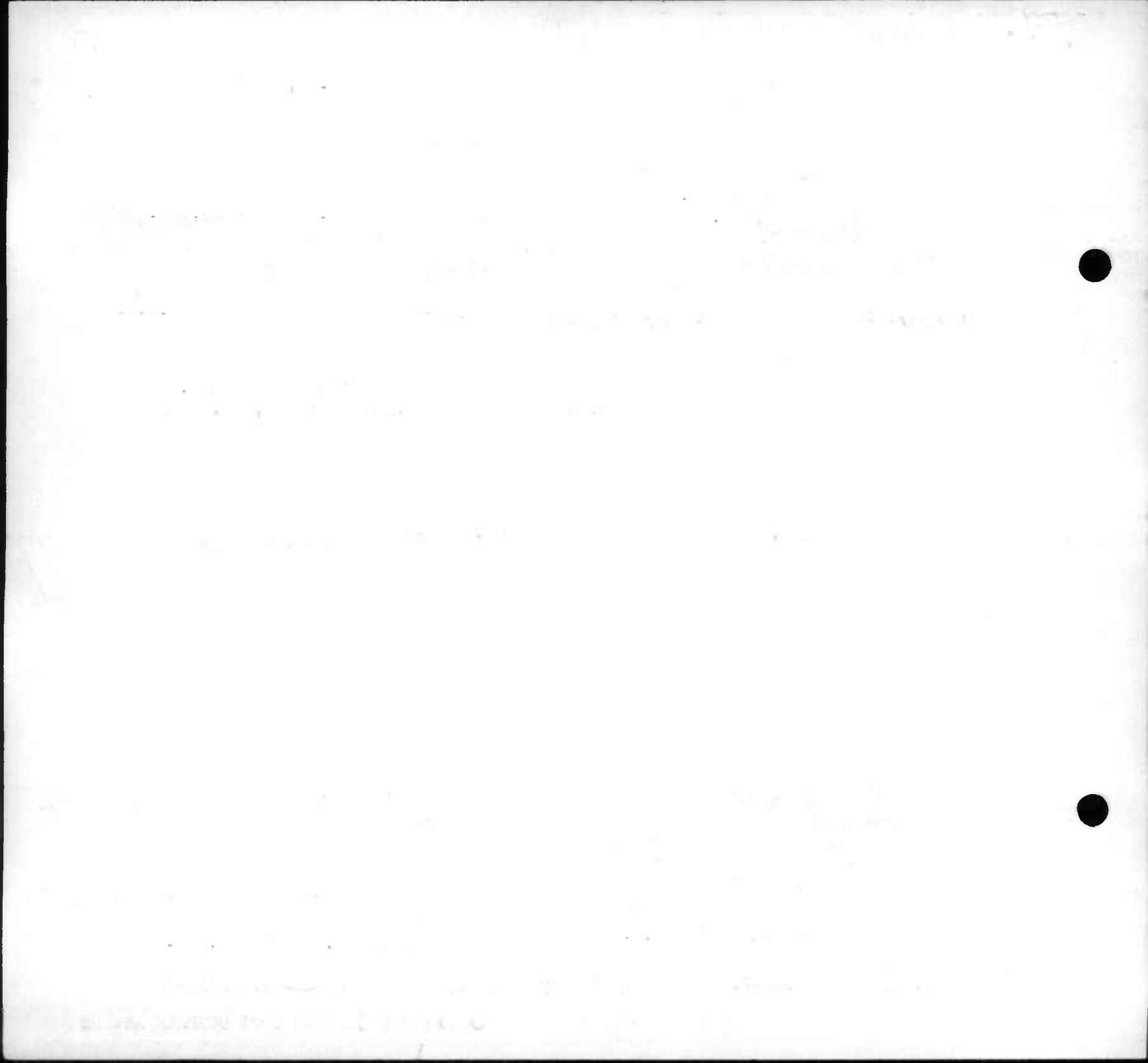
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>D-151</u>		72 00114		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00114	
1. NAME OF DECEASED (Type or Print) <u>Davenport, Inez</u>				2. DATE AND HOUR OF DEATH <u>1-1-72 at 10:45 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2646</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>6208 Plantview Way</u>									
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-00</u>	9. AGE (in years last birthday) <u>71</u>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Worthington</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Baltimore City-Records</u>				
18. <u>189.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia, E. coli</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Renal Cell Carcinoma, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Arteriosclerotic Cardiovascular</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 mo</u>	
MEDICAL CERTIFICATION									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Cardiovascular</u>									
19A. DATE OF OPERATION <u>1/2/72</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bicopsy, LHR mass</u>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/6/71</u> 19 to <u>1/1/72</u> 19 that (I) (we) last saw the deceased alive on <u>1/1/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Robert N. Hill</u>				23B. DATE SIGNED <u>1/1/72</u>				23C. PHYSICIAN'S NAME (Type) <u>Robert N. Hill</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-5-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
25A. DATE RECD BY HEALTH DEPT. <u>JAN 7 1972</u>				25B. NAME OF REGISTRAR <u>WALTER DABROWSKI</u>		25C. FUNERAL DIRECTOR <u>1005 DUNDALK AVENUE</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

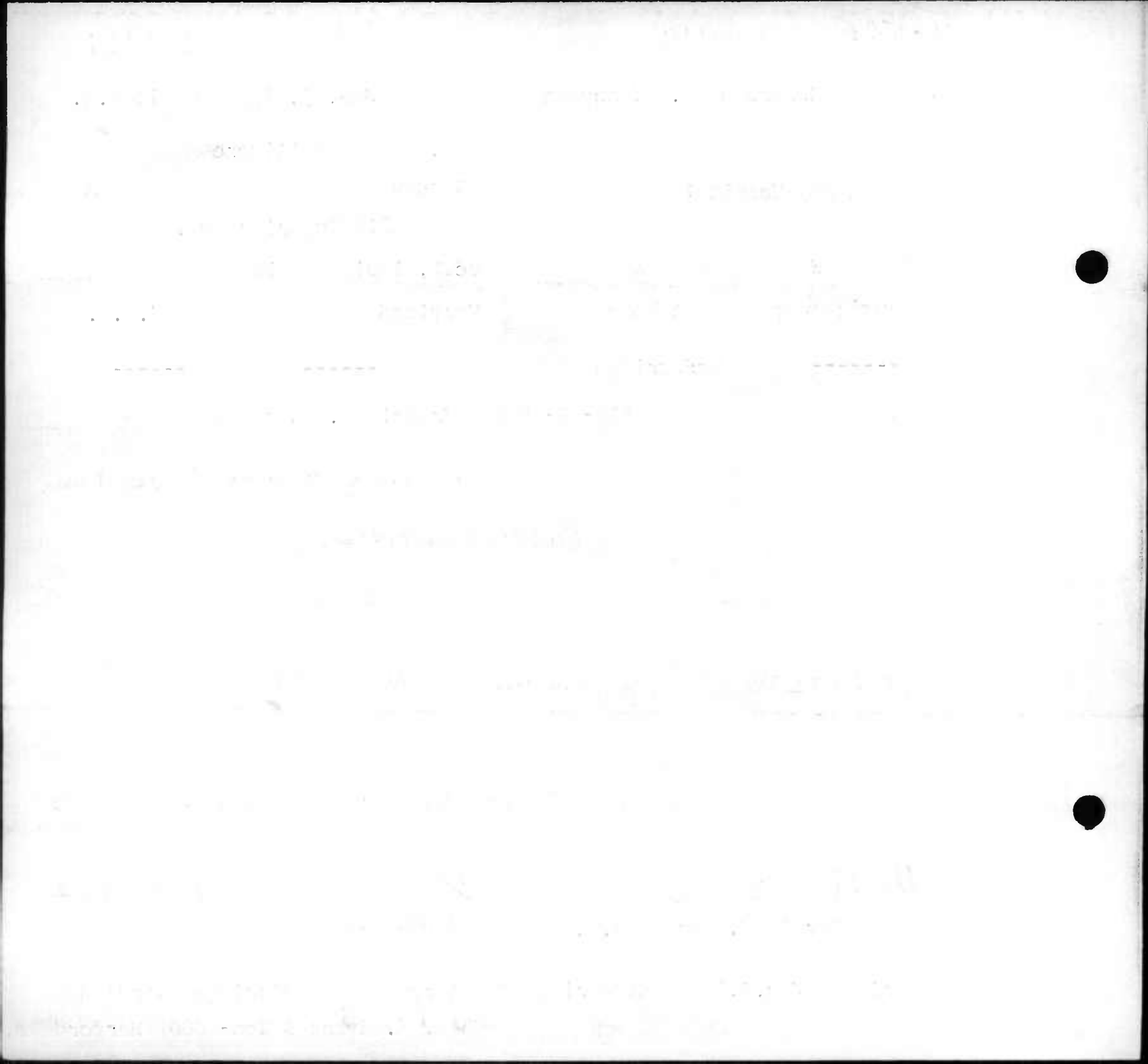
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
L-200		72 00115		72 00115		72 00115	
1. NAME OF DECEASED (Type or Print) John Lowshoe				2. DATE AND HOUR OF DEATH Jan. 3, 1972 11:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1712 Bayard Ave. Baltimore, Md. 21222			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-99	9. AGE (in years last birthday) 72	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosp. Att.		10B. KIND OF BUSINESS OR INDUSTRY St Mary Hospital		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Lowshoe				14. MOTHER'S MAIDEN NAME Josephine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-10-7959		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 250.91 Cerebrovascular accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/13/71 to 1/13/72 that (I) (we) last saw the deceased alive on 1/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert L. Ruxin M.D.				23B. DATE SIGNED 1/13/72			
23C. PHYSICIAN'S NAME (Type) Robert L. Ruxin M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-8-71		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert L. Ruxin M.D.		25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-525 72 00116		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00116	
1. NAME OF DECEASED (Type or Print) <b>Gertrude M. Tennyson</b>			2. DATE AND HOUR OF DEATH <b>Jan. 3, 1972 10 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Carney</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2814 Superior Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Dec. 2, 1901</b>	9. AGE (in years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>McFatrige</b>			14. MOTHER'S MAIDEN NAME <b>-----</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-0507</b>		17. INFORMANT <b>Francis A. Hanrahan</b> ADDRESS <b>Same</b>	
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Carcinomatous</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>-----</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1-12-29-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma - Jejunum</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-----</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-----</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-----</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-----</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12-28-1971</b> to <b>1-3-1972</b> that (I) (we) last saw the deceased alive on <b>19</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold H. Burns</b>			23B. DATE SIGNED <b>1-5-1972</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Harold H. Burns M.D.</b>			23D. ADDRESS <b>8106 Harford Road</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 5, 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Medowridge Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Elkridge Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>			
25B. NAME OF REGISTRAR <b>Chas. F. Evans</b>		25C. FUNERAL DIRECTOR <b>Chas. F. Evans &amp; Son - 8802 Harford Rd.</b>			

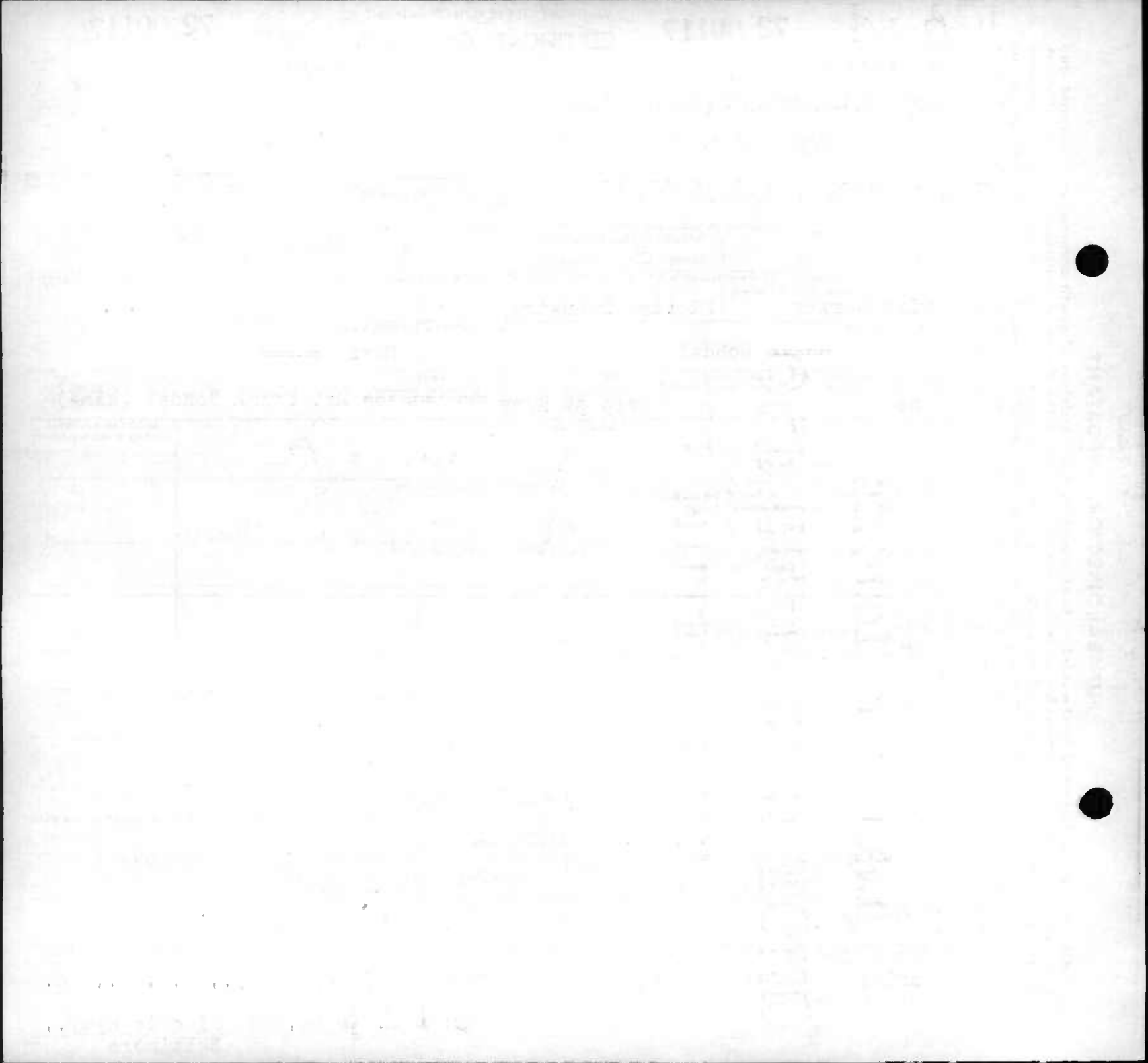


# **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00117	
B-340 72 00117					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Bohdal - Stephen J</u>			2. DATE AND HOUR OF DEATH <u>1/1/72</u> <u>14:40 am</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>5221 6th St</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/82</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>wire worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Florist Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Chego</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Bohdal</u>			14. MOTHER'S MAIDEN NAME <u>Dora</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219 32 2700</u>		
17. INFORMANT <u>Mr. Frank Bohdal (same)</u>			ADDRESS		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic cardiovascular disease</u> (C) <u>nil</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>nil</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>nil</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>nil</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>nil</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>nil</u>	
21D. TIME OF INJURY (APPROX.) <u>nil</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>nil</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>12-31-1971</u> to <u>1-1-1972</u> that (1) (we) last saw the deceased alive on <u>1-1-1972</u> and that (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Sirithara</u> M.D. DEGREE				23B. DATE SIGNED <u>1/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. SIRITHARA</u> M.D. DEGREE				23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/4/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>	
24D. LOCATION <u>Ritchie Hgwy., A.A.Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>John E. Feltz, Jr.</u>		25C. FUNERAL DIRECTOR <u>George J. Conce</u>	
ADDRESS <u>4001 Ritchie Hgwy., Baltimore</u>					

Margaret Sawyer





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 3-140				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00118			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
SPELL, Ocie Elwood				January 1, 1972 9:11 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Holliday and Fayette Streets							
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-25-04	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier Repairman						
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Daniel P. Spell				14. MOTHER'S MAIDEN NAME Lessie D. Holt							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3-30-42 to 12-3-43				16. SOCIAL SECURITY NO. 250-20-07-18		17. INFORMANT Records ADDRESS VAN, 3900 Loch Raven Blvd., Balto., Md. 21218					
18. 41231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Cirrhosis of liver, Marked advanced with ascites, Gastro Intestinal hemorrhage Moderate (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis of coronary arteries and of thoracic and abdominal aorta, advanced (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pulmonary congestion moderate				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from December 5, 1971 to January 1, 1972, that (X) (we) last saw the deceased alive on January 1, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.											
23A. SIGNATURE M. Goldberg M.D.				23B. DATE SIGNED 1/2/71		23C. PHYSICIAN'S NAME (Type) Marc Goldberg M.D.					
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) 1/3/72				24C. NAME OF CEMETERY OR CREMATORY Highland Biological Garden		24D. LOCATION (City, town, or county) (State) RAEFORD, North Carolina					
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR WILLIAM JOHNSON FUNERAL DIR.		ADDRESS 8521 LOCHRAVEN BLVD.					

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BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) John Floystad				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 1 72 3:05 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 3:05 A. M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 1, 1909				10. AGE (in years lost birthday) 62		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? Norway				13. FATHER'S NAME Gierull Emmanuel Floystad		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				16. KIND OF BUSINESS OR INDUSTRY C & E Julio		17. MOTHER'S MAIDEN NAME Nikoline Nilssen	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS Elly Floystad - 8322 Philadelphia Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-1-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-71		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Miller, R.C.		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		25D. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00120</b></p>	
<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>VINCENT SCHUMAN</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>1-1-72 7.05 P M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b> Church Home &amp; Hospital</p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>Baltimore</b></p> <p><b>5. CITY OR TOWN</b> <b>SPARROWS POINT</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <b>729 E ST. SPARROWS PT.</b></p>	
<p><b>6. SEX</b> <b>Male</b></p>	<p><b>7. RACE</b> <b>White</b></p>	<p><b>8. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>9. DATE OF BIRTH</b> <b>3-28-1896</b></p>
<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETD. Chauffeur Bethlehem Steel Co.</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b></p>	<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b></p>
<p><b>13. FATHER'S NAME</b> <b>GEORGE SCHUMAN</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Lena White</b></p>	
<p><b>15. Was Deceased Ever In U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>213-09-2992</b></p>	
<p><b>17. INFORMANT</b> <b>Wife:</b> <b>Mrs. Mary Alice Schuman</b></p>		<p><b>ADDRESS</b> <b>729 E St. Sparrows Point, Md.</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>410.9 I</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>15'</b></p>	
<p><b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b> <b>CARDIAC ASTHOLE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(B) MYOCARDIAL INFARCTION</b> <b>few hrs.</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(C) ASCVD</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY? (Yes or No)</b> <b>No</b></p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p><b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (this hospital) attended the deceased from 1-1-1972 to 1-1-1972 that (we) lost saw the deceased alive on 1-1-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>S. R. George M.D.</b></p>		<p><b>23B. DATE SIGNED</b> <b>1-1-72</b></p>	<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>S. R. GEORGE M.D.</b></p>
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>1-5-71</b></p>	<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b></p>
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 7 1972</b></p>	
<p><b>25B. NAME OF REGISTRAR</b> <b>John J. Duda</b></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>John J. Duda</b></p>	
<p><b>ADDRESS</b> <b>7922 Wise Ave. Dundalk, Md.</b></p>		<p><b>VS 150-REV. 1/1/68</b></p>	

1. The average of 12 TC = 4.2

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Orland H. Small				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 1 72 10:28 A.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 72 10:28 A.M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1/28/10				10. AGE (In years last birthday) 61		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF U. S. A.				13. FATHER'S NAME Small		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
15. MOTHER'S MAIDEN NAME Lillian ?				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes Navy 1928 - 1953			
17. SOCIAL SECURITY NO. 213-30-8792				18. INFORMANT (Wife) 7864 St. Fabian Lane, Mrs. Evelyn C. Small, Dundalk, Md.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				22D. TIME OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/5/71			
24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery				24D. LOCATION (City, town, or county) (State) Arlington, Virginia			
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972				25B. NAME OF REGISTRAR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



No.	Name of Person	Address	Remarks
1	John Doe	123 Main St, Springfield, Ill.	...
2	Jane Smith	456 Oak Ave, Chicago, Ill.	...
3	...	...	...
4	...	...	...
5	...	...	...
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95	...	...	...
96	...	...	...
97	...	...	...
98	...	...	...
99	...	...	...
100	...	...	...



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 00122	
M-263		CERTIFICATE OF DEATH		REG. NO. 72 00122	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mc WHORTER, JOHN Scott, Jr.		1/4/72 1972		7:30 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
44 UNION MEMORIAL HOSPITAL, Balt. MD		Md. Hartford Co. 6232			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M.		W.		WIDOWED <input checked="" type="checkbox"/> - DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ATTORNEY RETIRED		FEDERAL LAND BANK		WEST VIRGINIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN Scott Mc WHORTER, Sr.		JENNIE Pearl McWhorter		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) 1-603-673-2278 ADDRESS	
No		220-34-5490		Miss M. Scott McWhorter Milford, New Hampshire 03055	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CARCINOMA OF LUNG			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW OLD INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/3/71 19 71 to 1/4/72 19 72 and that (I) (we) last saw the deceased alive on 1/4/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
R. DEC BUSTO		1/4/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Entombment		JAN. 7, 1972		Dulaney Valley Memorial Gardens Mausoleum	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 7 1972		JOSEPH L. FOSTER		W. Broadway & Williams St. Balt. Md. 21014	

Handwritten notes at the top left, including "2. A - 53" and "(Handwritten text)".

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Handwritten text in the lower middle section, possibly "Handwritten text".

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

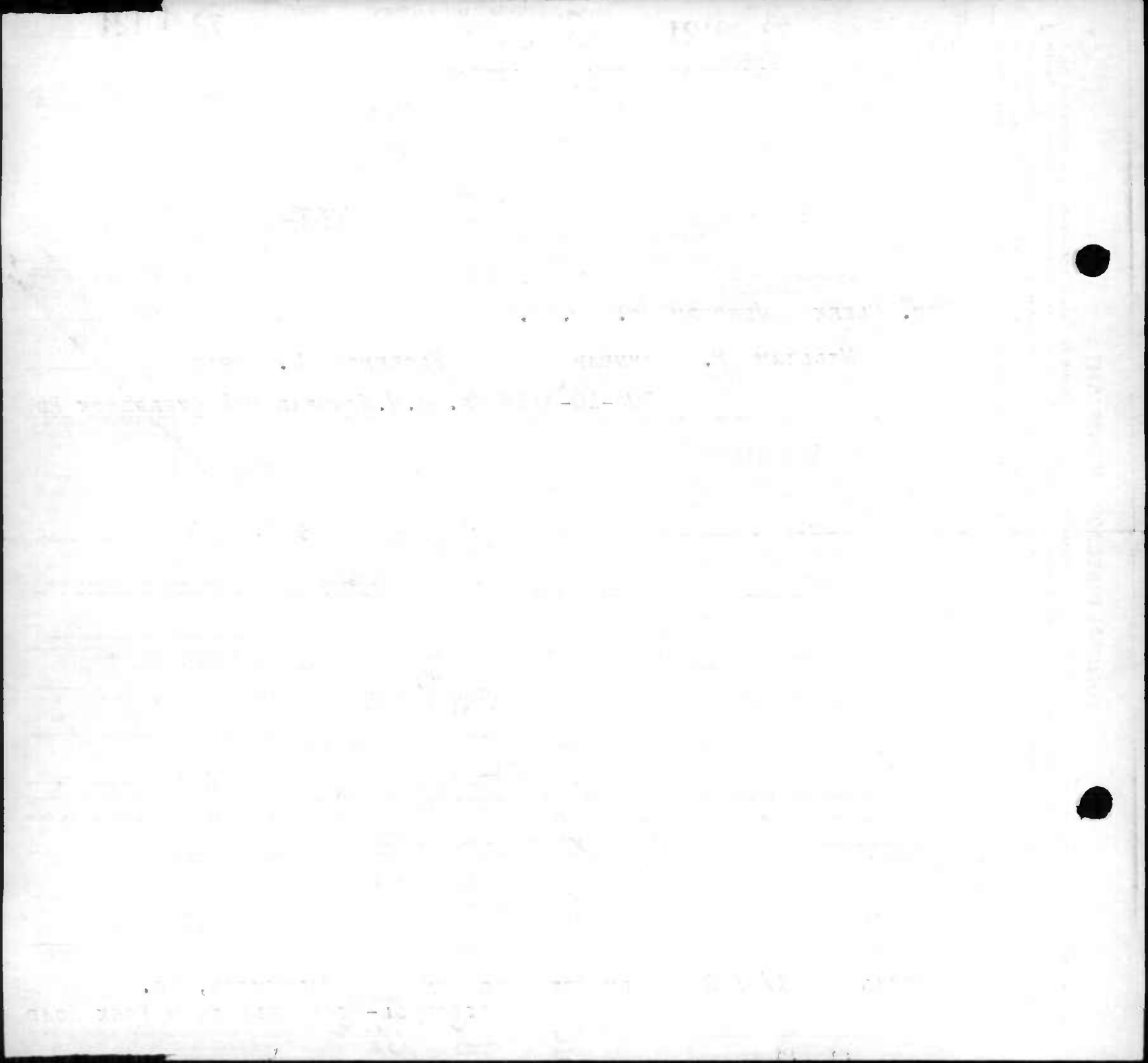
6-625		72 00123		BALTIMORE CITY HEALTH DEPARTMENT		72 00123	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>IEIK GRUZIN</b>				2. DATE AND HOUR OF DEATH <b>Jan 4, 1972 13:40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2831</b>			
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1/5/27</b>		9. AGE (In years last birthday) <b>44</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (State or foreign country) <b>Lith-Kovana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>				13. FATHER'S NAME <b>Chaim Gruzin</b>			
14. MOTHER'S MAIDEN NAME <b>Hannah</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>---</b>				17. INFORMANT <b>Evelyn Gruzin - same</b>			
18. <b>431.01</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(A) IMMEDIATE CAUSE <b>Intracerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Severe Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>---</b>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 hr</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> 19 <b>72</b> to <b>1/4</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert L. Brenner, M.D.</b>				23B. DATE SIGNED <b>1/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Robert L. Brenner, M.D.</b>	
23D. ADDRESS <b>Sinai Hospital</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/5/72</b>				24C. NAME OF CEMETERY or CREMATORY <b>Chesapeake American Cong</b>		24D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>				25B. NAME OF REGISTRAR <b>Robert L. Brenner, M.D.</b>		25C. FUNERAL DIRECTOR <b>6018 Reister Rd.</b>	
25D. ADDRESS <b>6018 Reister Rd.</b>				VS 150-REV. 1/1/68			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

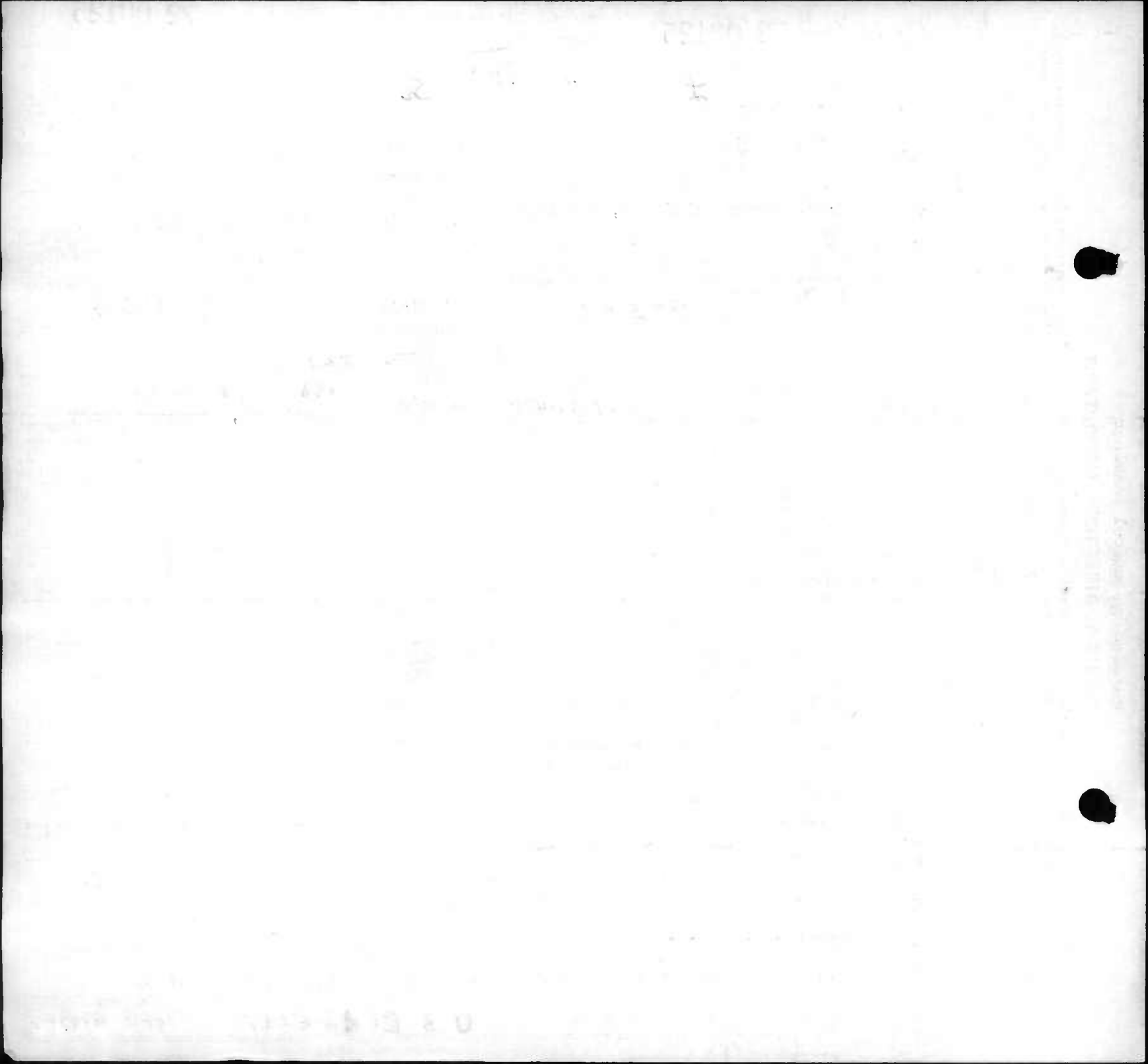
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00124	
K-560 72 00124					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>FLORENCE EDNA KINNEAR</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 1 1972 10:30p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>907</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1656 ABBOTTSTON ST.</b>					
5. SEX <b>W F</b>	6. RACE <b>F</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02/14/1893</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. CLERK WESTERN MD. R. R.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM M. KINNEAR</b>			
14. MOTHER'S MAIDEN NAME <b>FLORENCE W. OHLE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>705-10-5119</b>			
16. SOCIAL SECURITY NO. <b>705-10-5119</b>		17. INFORMANT <b>MR. J.H. KINNEAR 222 OVERBROOK RD</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEMORRHOIC SHOCK</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HEMORRHOIC SHOCK</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>GASTROINTESTINAL BLEEDING</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>GASTRIC CARCINOMA</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/29/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21C. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21E. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/29/71</b> 19__ to <b>1/1/72</b> 19__ that (I) (we) last saw the deceased alive on <b>1/1</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1/1/72</b>		23C. PHYSICIAN'S NAME (Type) <b>CEGAR WILSON</b>	
23D. ADDRESS <b>33rd and Calvert St.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>1/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Bea...</b>		25C. FUNERAL DIRECTOR <b>MICHELLE WIEDEFELD 6500 YORK ROAD</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>HAROLD L. MCGRAW</b>		2. DATE AND HOUR OF DEATH <b>1-4-1972 10.05 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7519 Belmont Avenue 21224</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-27-1929</b>	9. AGE (in years last birthday) <b>42</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph</b>			
14. MOTHER'S MAIDEN NAME <b>Cora REEDY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>			
16. SOCIAL SECURITY NO. <b>224-324750</b>		17. INFORMANT <b>BCH-Records</b> ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>			
18. <b>41017 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>5-7-1969</b> to <b>January 4 1972</b> , that (2) (we) last saw the deceased alive on <b>January 4 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James Young M.D.</b>		23B. DATE SIGNED <b>1-4-1972</b>		23C. PHYSICIAN'S NAME (Type) <b>James Young M.D.</b>	
23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue Balto, Md 21224</b>		24. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/7/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM</b>	
24D. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		24E. NAME OF REGISTRAR <b>James Young</b>		24F. FUNERAL DIRECTOR <b>O. E. COAKLEY</b>	
24G. ADDRESS <b>300 MACE</b>		25. NAME OF REGISTRAR <b>James Young</b>			





G-630

72 00126

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00126

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ARTHUR GRAY GRADY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1418 Light Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 5, 1972 12:21 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2302</b>	
9. DATE OF BIRTH <b>16 MAY 1930</b>		10. AGE (In years lost birthday) <b>41</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ARLIE GRADY</b>		14. STREET AND NUMBER <b>1418 Light Street</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>CITY OF BALTIMORE</b>	
15. MOTHER'S MAIDEN NAME <b>HELEN MICHIE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-NO-</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>WHITTEN FUNERAL HOME 1336 PARK AVE. LYNCHBURG, VIRGINIA</b>	
19. <b>E 9551 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Gunshot wound of head</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes (Head-only)</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1418 Light Street, 3rd floor 2302</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>Unknown</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Self-inflicted</b>		23. (Head-Only) I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1/5/72</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL/BURIAL</b>	
24B. DATE <b>7 JAN '72</b>		24C. NAME OF CEMETERY or CREMATORY <b>VIRGINIA MEMORIAL PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BEDFORD CO. VA.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>	
25B. NAME OF REGISTRAR <b>W. S. 1 2 0 0 0</b>		25C. FUNERAL DIRECTOR ADDRESS <b>WHITTEN FUNERAL HOME 1336 PARK AVE LYNCHBURG, VA.</b>	

29101 ST

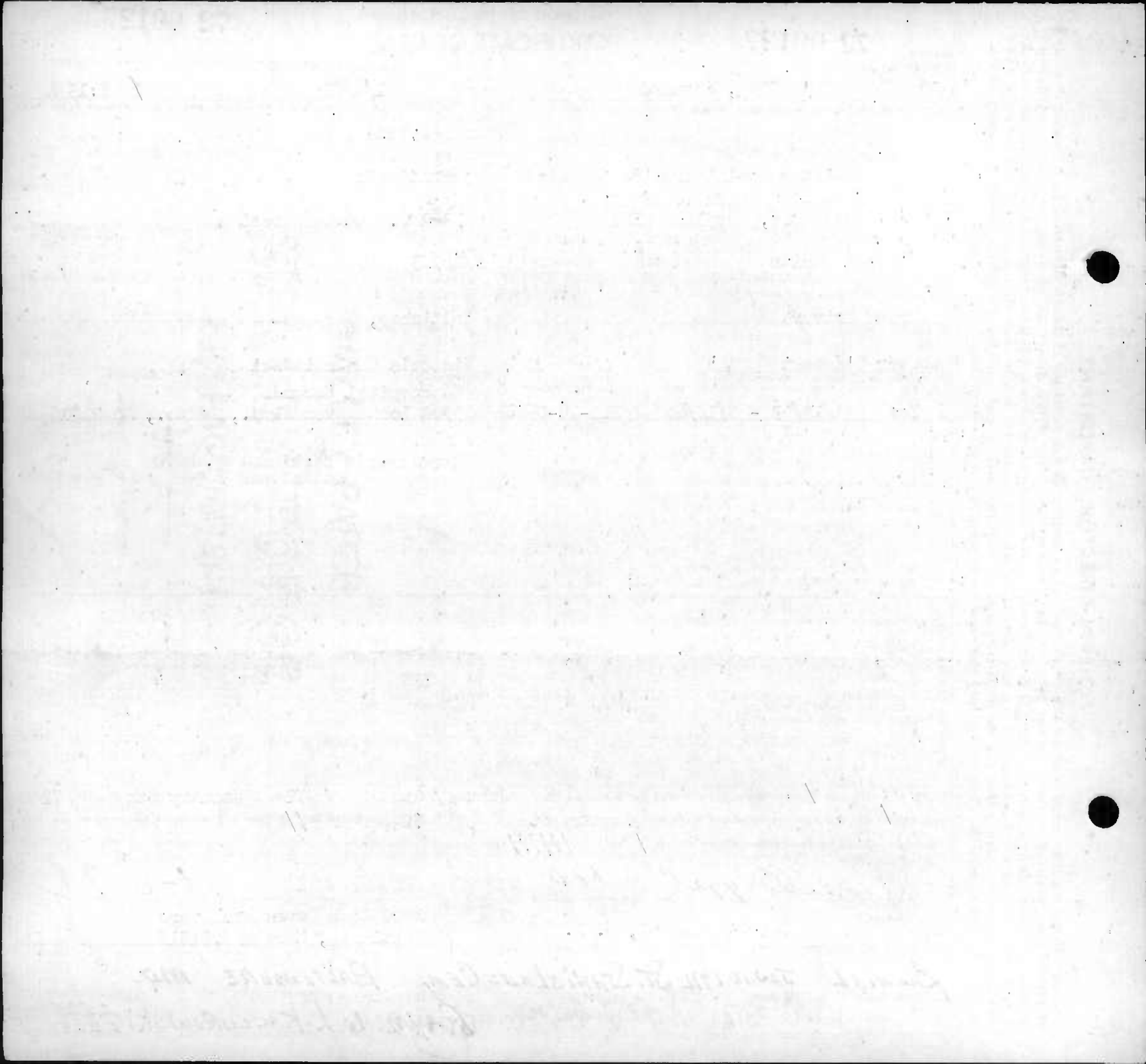
29101 ST

*[Handwritten signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 00127				CITY HEALTH DEPARTMENT				REG. NO. 72 00127			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
O'KONSKI, Bernard				1/6/72 8:15 A. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY							
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland 105							
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)							
Male White				5/24/23 48 Truck driver							
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
Baltimore, Maryland				USA							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Walter O'Konski				Victoria Chmieliawski							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.							
Yes 1/19/43 - 3/16/46				213-18-0388							
17. INFORMANT				ADDRESS							
VA Hospital Records				3900 Loch Raven Blvd., Balto., Md 21218							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH							
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				Bronchogenic carcinoma with metastases							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)							
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. HOW DID INJURY OCCUR?							
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/>											
22. I certify that (I) (this hospital) attended the deceased from January 4th 19 72 to January 6th 19 72, that (I) (we) last saw the deceased alive on January 6th 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Jerome Koeppel, M. D.				1-6-72							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Jerome Koeppel, M. D.				3900 Loch Raven Boulevard Baltimore, Maryland 21218							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE							
BURIAL				JAN 10 1972							
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)							
ST. STANISLAUS CEM.				BALTIMORE MD.							
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR							
JAN 7 1972				Robert E. Taylor, M.D.							
25C. FUNERAL DIRECTOR				ADDRESS							
RAYMOND L. KACZOROWSKI				2525 FLEET ST.							



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

72 00128

BIRTH NO.

72 00128

1. NAME OF DECEASED  
(Type or Print)

JOHN GARMAN

2. DATE AND HOUR OF DEATH

JANUARY 3, 1972 | 4<sup>35</sup> P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31

Baltimore City Hospital  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MD.

Baltimore

103

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6813 ROBERTS AVENUE 21224 AVE

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10/29/95

9. AGE (in years  
last birthday)

76

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY GARMAN

14. MOTHER'S MAIDEN NAME

MARY

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213-07-440

17. INFORMANT

BCH RECORDS:

ADDRESS  
4940 Eastern Avenue  
Baltimore, Maryland 21224

18. 162.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIORESPIRATORY ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

BRONCHOGENIC CARCINOMA of  
LUNG.

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from January 3 19 72 to January 3 19 72  
that (X) (we) lost saw the deceased alive on January 3 19 72 and that in (X) (our) opinion death occurred on the date  
and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Reed MD

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

Jan 3, 1972

23C. PHYSICIAN'S  
NAME (Type)

Richard Reed LOVE MD

23D. ADDRESS

Baltimore City Hospitals.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

1/7/72

OAKLAWN CEMETERY

BALTIMORE CO MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

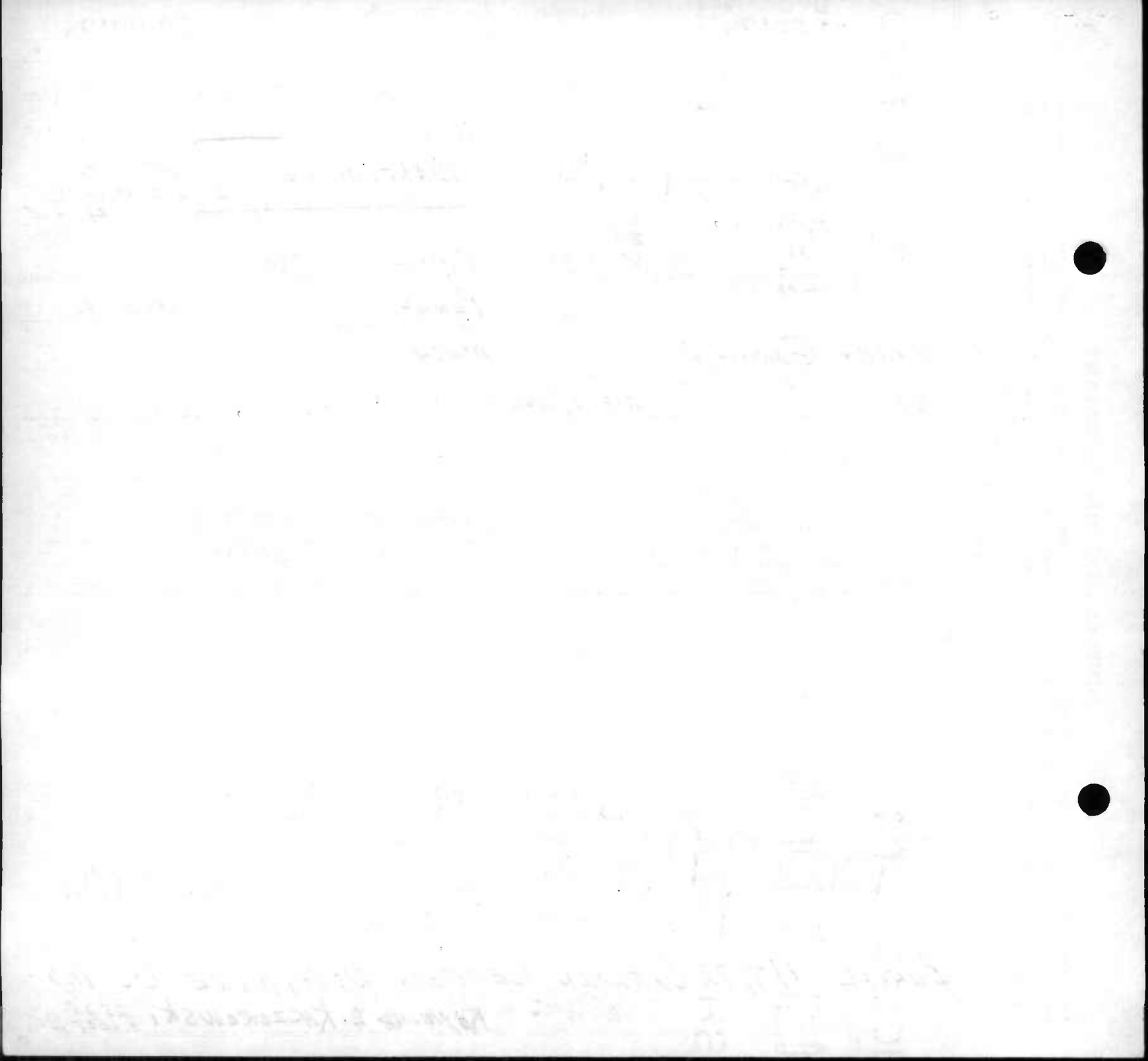
25C. FUNERAL DIRECTOR

ADDRESS

JAN 7 1972

WILLIAM E. GIBBS MD

RAYMOND J. KACZOROWSKI 2525  
E. 1ST ST.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>VINCENT BATEMAN</b> Woodrow Williams		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 2 72 8:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1430 W. Baltimore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 2 72 8:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (in years lost birthday) 48		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) MARYLAND		E. STREET AND NUMBER 1430 W. Baltimore Street	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAAC WILLIAMS	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		15. MOTHER'S MAIDEN NAME BLANCHE LONG	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		17. SOCIAL SECURITY NO. 212-36-3121	
18. INFORMANT MRS. H. SPIELMAN 6115 GLOVER ST. #24		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CIRRHOSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-2-72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 6 1972	
24C. NAME OF CEMETERY or CREMATORY CEDAR HILL Cem.		24D. LOCATION (City, town, or county) (State) BALTO Co MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Raymond L. Kaczorowski		ADDRESS 2525 FLEET ST.	

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

4. The fourth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

5. The fifth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

6. The sixth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

7. The seventh part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

8. The eighth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

9. The ninth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

10. The tenth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

11. The eleventh part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

12. The twelfth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

13. The thirteenth part of the document is a letter from the President to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new President to the new Congress.

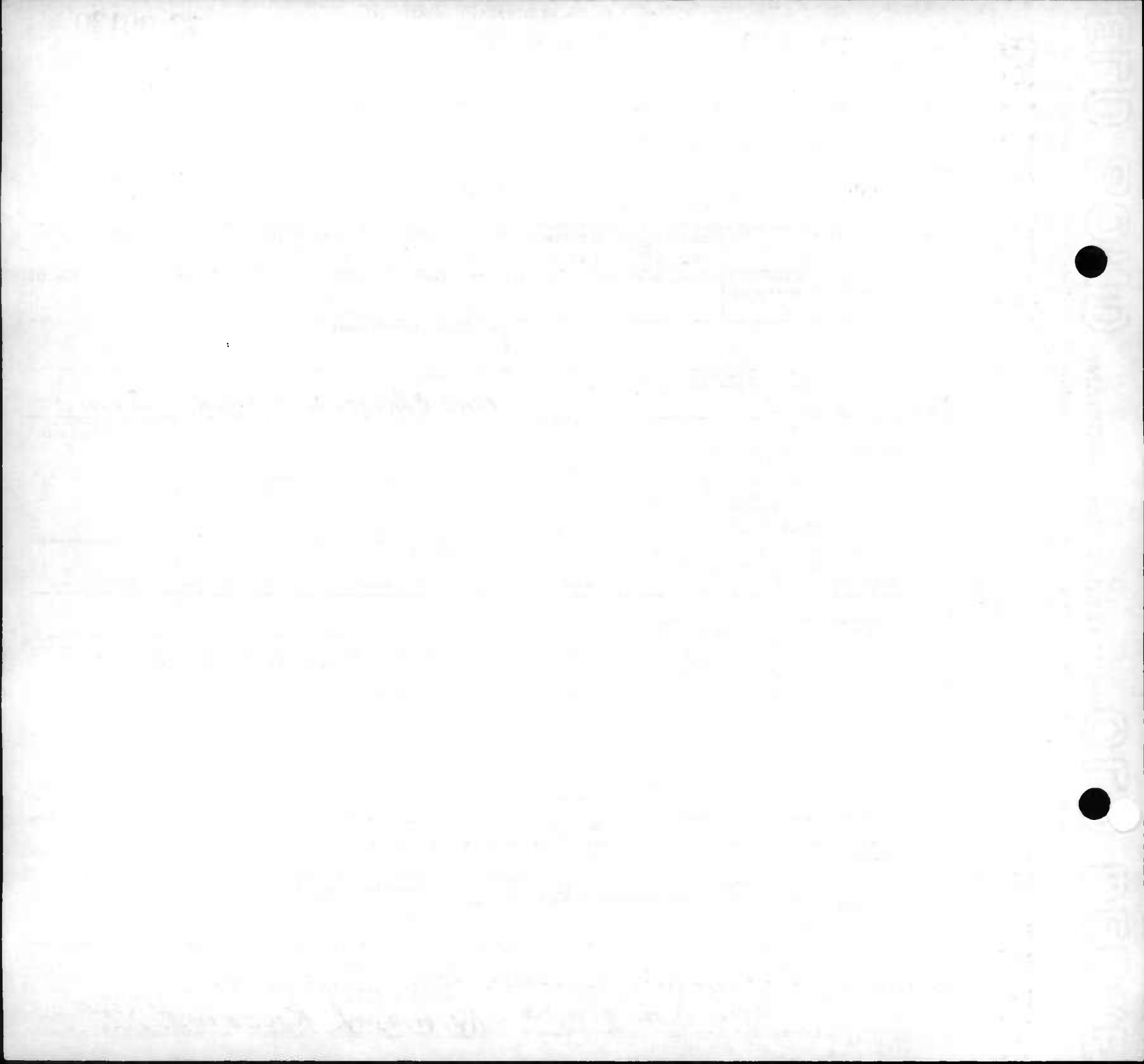


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00130

BIRTH NO. <u>72 00130</u>		1. NAME OF DECEASED (Type or Print) <u>ARTHUR, MR. STEPHEN E.</u>		2. DATE AND HOUR OF DEATH <u>11/1/72 10:35 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME HOSPITAL</u> <u>100 NORTH BROADWAY ST.</u>				A. STATE <u>MARYLAND.</u> B. COUNTY <u>101</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE (City)</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2819 HUDSON ST. 21224</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08/09/24</u>	9. AGE (In years last birthday) <u>47</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED.</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>
13. FATHER'S NAME <u>THOMAS ARTHUR</u>			14. MOTHER'S MAIDEN NAME <u>MARGARET HERR.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>			16. SOCIAL SECURITY NO. <u>220 14 8907</u>		17. INFORMANT <u>MRS. CHRISTINA ARTHUR</u> ADDRESS <u>SAME</u>
18. <u>571.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC COMA.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>CIRRHOSIS OF THE LIVER.</u> <u>(B) SEVERE HEPATIC INSUFFICIENCY.</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>alcoholism</u> <u>many years</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/14/71</u> 19 <u>  </u> to <u>11/1/72</u> 19 <u>  </u> that (I) (we) last saw the deceased alive on <u>11/1/72</u> 19 <u>  </u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dietrich V. Feldmann MD</u> DEGREE				23B. DATE SIGNED <u>11/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DIETRICH V. FELDMANN MD</u> DEGREE				23D. ADDRESS <u>CHH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>JAN 6, 1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>	
24D. LOCATION <u>BALTIMORE</u>		(City, town, or county)		(State) <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>Raymond D. Kaczorowski</u>		25C. FUNERAL DIRECTOR <u>Raymond D. Kaczorowski</u> ADDRESS <u>3525 FLEET ST.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

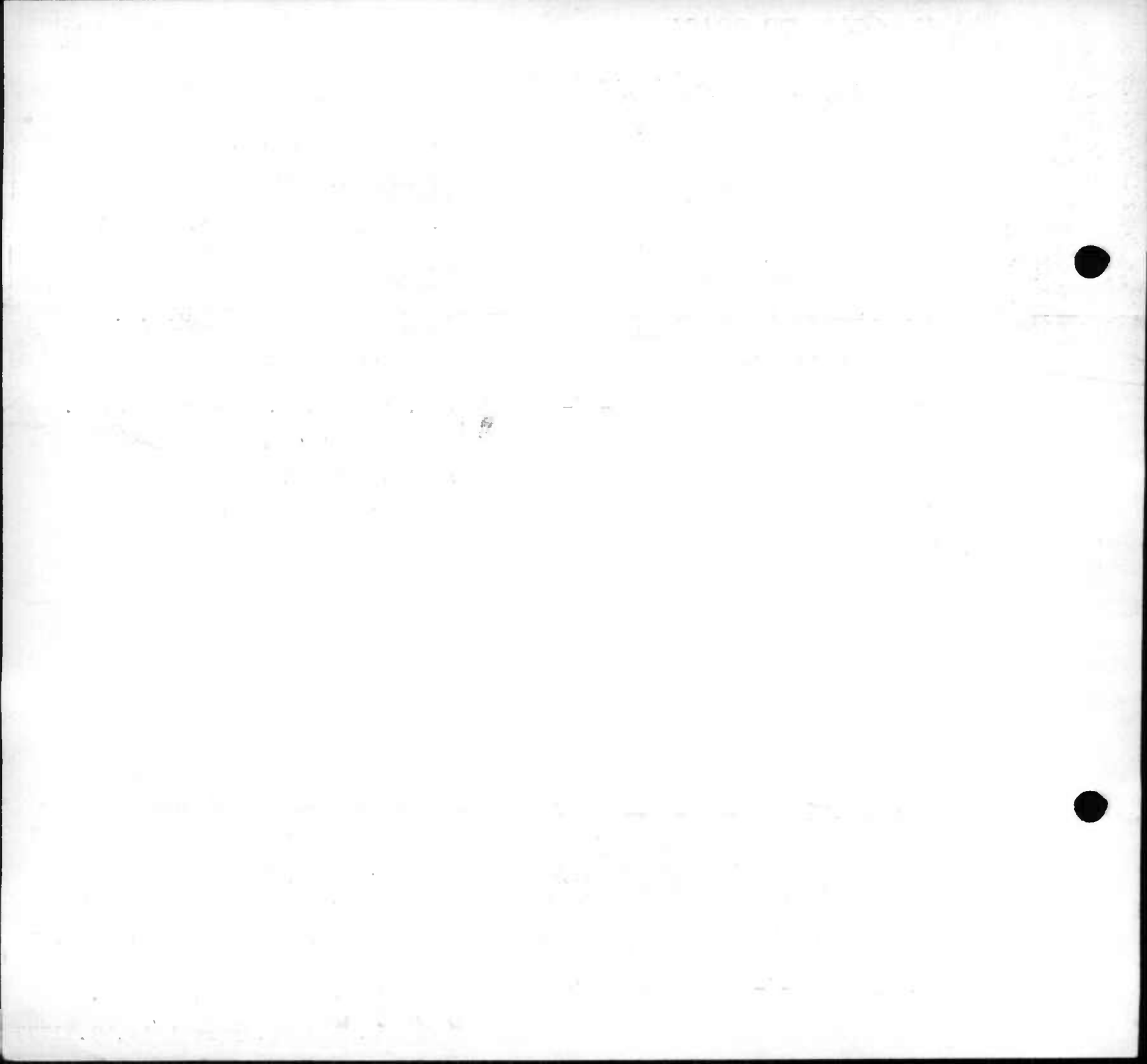
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 72 00131

BIRTH NO. R-150 72 00131


1. NAME OF DECEASED (Type or Print) <u>Rippeon, Mary M.</u>		2. DATE AND HOUR OF DEATH <u>1-3-72 4:35 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Frederick</u> C. CITY OR TOWN <u>Meyersville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Rt. 2 Meyersville, Md. 21773</u>	
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>41</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roger Stull</u>		14. MOTHER'S MAIDEN NAME <u>Olive Black</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-26-5009</u>	
17. INFORMANT <u>Roy E. Rippeon, Rt. 2 Myersville, Md.</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Thrombocytopenia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>?</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>no</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <input type="checkbox"/>		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from <u>1-2-72</u> 19 to <u>1-3-72</u> 19 that (2) (we) last saw the deceased alive on <u>1-3-72</u> 19 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>George J. Taylor MD</u>		23B. DATE SIGNED <u>1-3-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>George J. Taylor MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital Baltimore, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-6-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Resthaven Memorial Gardens, Frederick, Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Paul F. Bittle</u>		ADDRESS <u>Myersville, Md. 21773</u>	

VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00132</span>				CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 00132</span>	
P-625 72 00132				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LAURETTA K. MORGAN PEIRSON</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 6/72 1 8 a. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1202</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3100 ST. PAUL ST.</b>		HOPKINS APTS. <b>21218</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884 08/17/1884</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND (Balto)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MATHIAS KIEFER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET MORGAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>J1 220-44-3713</b>		17. INFORMANT: son Hopkins Apts. ADDRESS 21218 Wm. O. Peirson, 3100 St. Paul St., Balto.			
18. <b>440.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ARTERIO-SCLEROSIS</b>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/5 1972</b> to <b>1/6 1972</b> that (I) (we) last saw the deceased alive on <b>1/6 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR VILLANAR INTERN</b>				23D. ADDRESS <b>33rd and Calvert ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/8/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D. 2</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North City</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00133

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BOLES T. BAUTRO

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

January 5, 1972

1:30 A.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

101

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8-31-03

10. AGE (In years  
lost birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3007 Hudson Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Adam F. Bautro

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14b. KIND OF BUSINESS OR INDUSTRY

Communication

15. MOTHER'S MAIDEN NAME

Stanislawa Ribacka

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

19. No

17. SOCIAL  
SECURITY NO.

214-03-4277

18. INFORMANT

Mrs. Marie Bautro

ADDRESS

3007 Hudson St., Baltimore, Md.

CAUSE OF DEATH

Fracture of cervical and thoracic  
vertebraeAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty metamorphosis of liver

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

3007 Hudson Avenue

101

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

1-4/5/1971

?

m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Fell at home

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/5/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-8-72

24C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 7 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3021 Eastern Ave., Baltimore, Md.

10104 55

10104 55





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <u>72 00134</u></p>	
<p>BIRTH NO. <u>S-150</u> <u>72 00134</u></p>		<p>DATE AND HOUR OF DEATH <u>1/5/72</u> <u>1</u> <u>4</u> <u>P.M.</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Spahn - Charles</u></p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>Geo Washington Nursing Home</u></p>		<p>A. STATE <u>BALTO.</u> B. COUNTY <u>5900</u></p>	
<p>5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>4/3/1891</u> 9. AGE (In years last birthday) <u>80</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer RETIRED</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>	
<p>13. FATHER'S NAME <u>Conrad Spahn</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Miller</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>215-01-7502</u></p>	
<p>17. INFORMANT <u>Donna Price Lpa</u> ADDRESS <u>607 Penna - Baltimore</u></p>		<p>18. <u>492 X1</u> CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>EMPHYSEMA</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>PARAPARESIS WITH CERVICAL SPONDYLOSIS</u></p> <p>(C) <u>Prostatism - cystotomy</u></p> <p><u>Cor Pulmonale</u></p>	
<p>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>10 JUNE 1968</u> to <u>5 JAN 1972</u> that (I) (we) last saw the deceased alive on <u>4 JAN 1972</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</p>		<p>23A. SIGNATURE <u>Richard Tyson, M.D.</u> 23B. DATE SIGNED <u>4 JAN 72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>RICHARD TYSON MD.</u></p>		<p>23D. ADDRESS <u>936 W NORTH AVENUE</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>24B. DATE <u>JAN 8 1972</u> 24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD BALTO MD</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u> 25B. NAME OF REGISTRAR <u>Donna Price</u></p>	
<p>25C. FUNERAL DIRECTOR <u>DAPEL BROS INC</u> ADDRESS <u>7110 BELAIR ROAD</u></p>		<p>VS 150-REV. 1/1/68</p>	

6/9/69

3323 Wafford Ave, 21222

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <u>JOSE ALIMO</u>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>January 4, 1972</u> <u>8:30 P.</u> M.	
6. SEX <u>Male</u>		7. RACE <u>White</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <u>FEB 22 1915</u>		10. AGE (In years last birthday) <u>56</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>VINCENT ALIMO</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>	
15. MOTHER'S MAIDEN NAME <u>LARA CATANZARO</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO. <u>213-12-9887</u>	
18. INFORMANT <u>FREDERICK M. CICHORZ</u>		ADDRESS <u>1808 E PRATT ST</u>		19. CAUSE OF DEATH <u>Purulent meningitis</u>	
20. DATE OF OPERATION <u>2</u>		208. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>14 S. Poppleton Street</u>	
22D. TIME OF INJURY (APPROX.) <u>12-29-71 3:30 P.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Struck on head with pipe</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> EXAMINER'S NAME (Type)		DATE SIGNED <u>1/5/72</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24B. DATE <u>JAN 7 1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT CARMEL CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>ODONNELL ST BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HIPPEL BROS INC 1800 E LOMBARD ST</u>	

DEPT. OF JUSTICE

FEB 23 1952

BAKING NO

TRUCK DRIVER

NO

VINCENT ALIHO

LARA CATANZARO

23-13-000 FRANK M. CILKIN REE PART 2

*[Handwritten signature]*

RECEIVED BY THE DEPT. OF JUSTICE

RECEIVED BY THE DEPT. OF JUSTICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-250 72 00136		BALTIMORE CITY HEALTH DEPARTMENT		72 00136	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) DIXON, MAURICE O.		2. DATE AND HOUR OF DEATH 1/6/72 8:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1403 C. CITY OR TOWN Baltimore D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 533 Sanford Place			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/23	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Batto Gas & Electric		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MAURICE DIXON		14. MOTHER'S MAIDEN NAME LILLIAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 579-18-5209		17. INFORMANT CHANT - Marion Dixon 533 Sanford Pl.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Sepsis - Hypercalcemia DUE TO, OR AS A CONSEQUENCE OF: (B) perforation esophagus DUE TO, OR AS A CONSEQUENCE OF: (C) carcinoma of esophagus 6 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/2/30/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated esophagus		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) 21C. WHERE DID INJURY OCCUR? 21F. HOW DID INJURY OCCUR?	
22. I certify that (t) (this hospital) attended the deceased from 12/13 1971 to 1/6 1972 that (I) (we) last saw the deceased alive on 1/5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Sattenfield Jr MD		23B. DATE SIGNED 1/6/72		23C. PHYSICIAN'S NAME (Type) John R. Sattenfield Jr MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-10-72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION Anne Arundel City, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR 0000	
25C. FUNERAL DIRECTOR D.M. COMAR		25D. ADDRESS 928 E NORTH AVE			

75 00138

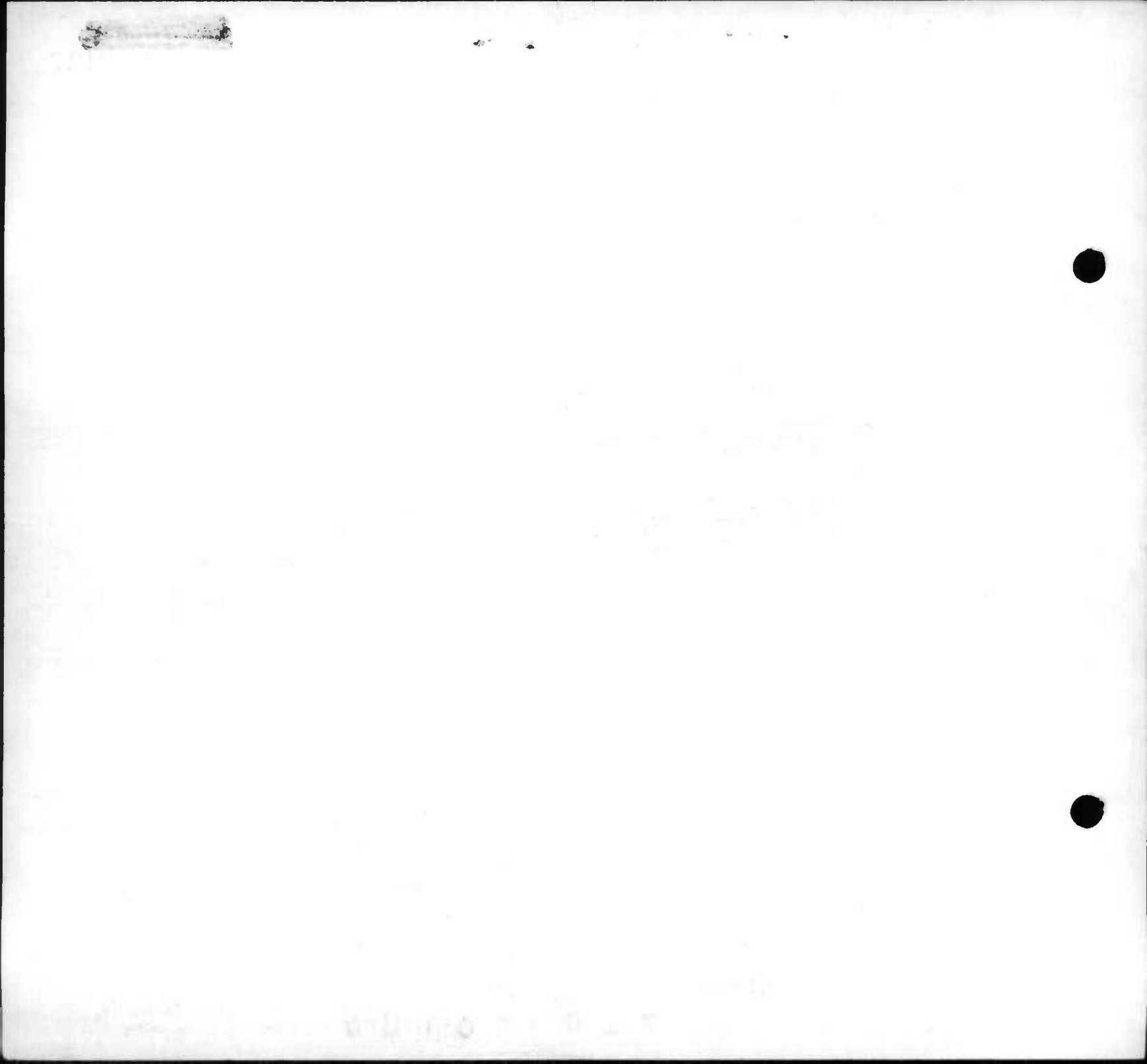
7-220

10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-120		72 00137		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
BIRTH NO.				72 00137			
1. NAME OF DECEASED (Type or Print) <b>CHARLES ROBIS</b>				2. DATE AND HOUR OF DEATH <b>1/3/72 6:35 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1102</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>46<sup>W</sup> BIDDLE ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-24-07</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENN</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or notes of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <b>4109</b> <b>NOT A MEDICAL EXAMINER'S CASE</b> DISEASE OR CONDITION DIRECTLY CAUSING DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc., it means the disease, injury or condition which caused death.) <b>CHIEF OR ASS'T. MEDICAL EXAMINER</b> <b>ANTICIPATED CAUSE</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) <b>Mitral Regurgitation</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (C) <b>Case</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> 19 <b>72</b> to <b>Jan 3</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Jan 3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Beltran, M.D.</b>				23B. DATE SIGNED <b>1/3/72</b>		23C. PHYSICIAN'S NAME (Type) <b>JUAN A. BELTRAN, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-5-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>John E. Kelly, Jr.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>			

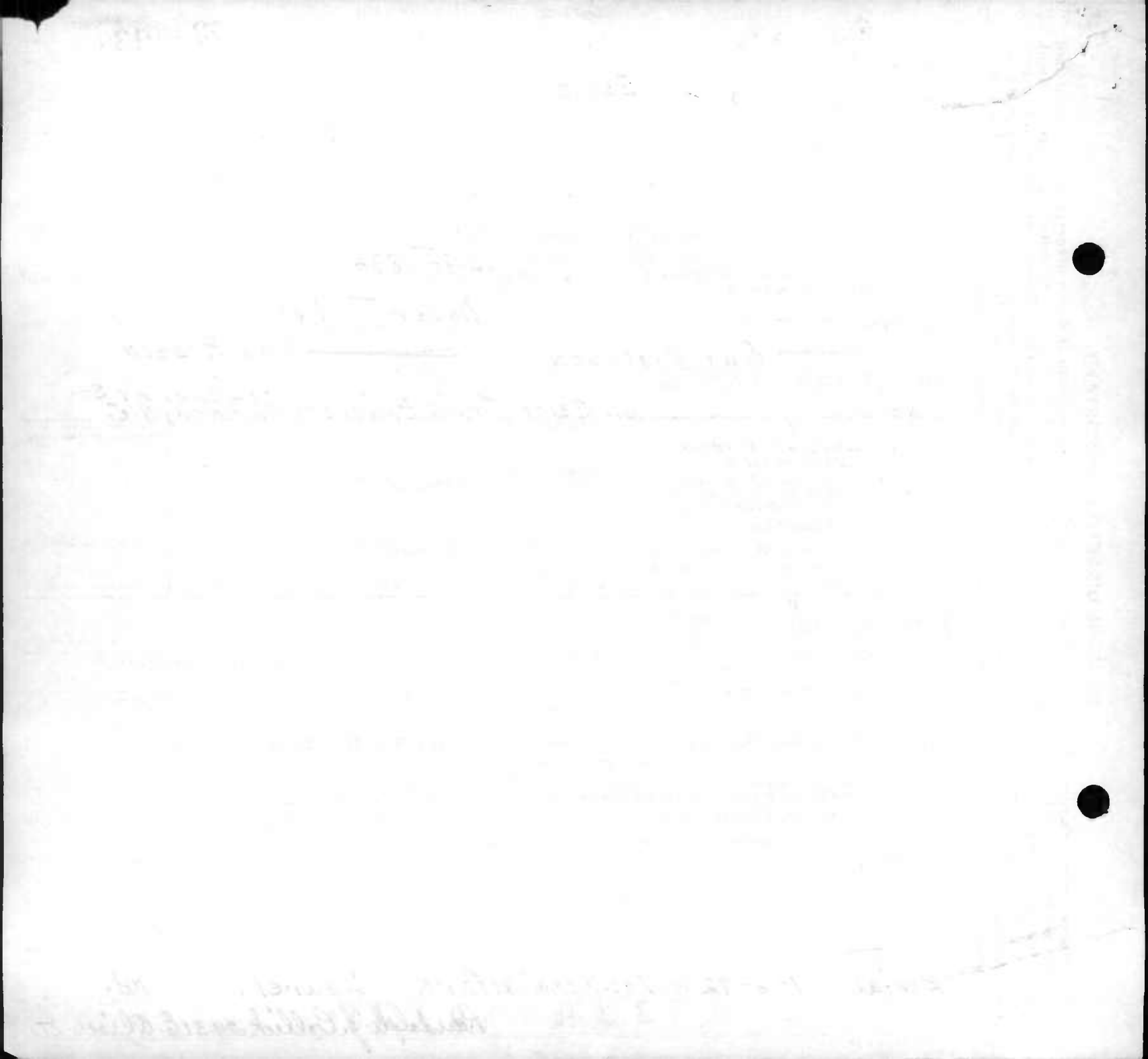




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00138</u>	
BIRTH NO. <u>72 00138</u>							
1. NAME OF DECEASED (Type or Print) <u>BARNES, ACA Essie</u>				2. DATE AND HOUR OF DEATH <u>1-1-72</u> <u>3:10</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-9-1896</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>75</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>Dover, Del.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNKNOWN John Anderson</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN Ella Alston</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-17-3109</u>		17. INFORMANT <u>Irvin Anderson Camden, N.J.</u>			
18. <u>412.2.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Vascular Accident.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCUD - HYPERTENSION.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CHF - Pelvic Mass?</u>			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>71</u> to <u>1-1</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Julio A. Dejo</u>				23B. DATE SIGNED <u>1-1-72</u>		23C. PHYSICIAN'S NAME (Type) <u>JULIO A. DEJO</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-6-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Md Nat. Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
25A. DATE RECD BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Randolph J. Collick 2431 E. Oliver St.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)VERNEAL VERNEL  
NESBIT, VERNON

2. DATE AND HOUR OF DEATH

Jan 1, 1972 1 1 20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 JOHNS Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2123 E. OLIVER ST.

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

XXXXX 8-9-09

9. AGE (in years  
last birthday)

62

10. Under 1 Yr.  
Months11. Under 24 Hrs.  
Days10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Puller

10B. KIND OF BUSINESS OR INDUSTRY

Steel Co.

11. BIRTHPLACE (State or foreign country)

Union Co., N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NESBIT, ROSEVELT

14. MOTHER'S MAIDEN NAME

ADA FAULKNER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-01-8850

17. INFORMANT

ADDRESS

Mrs Amy Nesbit 2123 E. Oliver St.

18. 431.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular Hemorrhage 4 hrs.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 hrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH Notify medical examiner21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-1-72 19 to 1-1-72 19  
that (I) (we) last saw the deceased alive on 1-1-19 72 and that (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. A. Gelfand M.D.

DEGREE

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/1/72

23C. PHYSICIAN'S  
NAME (Type)

J. A. GELFAND

DEGREE

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

1-5-72

Gardens of Eternal Hope

FINKSBURG,

Md.

25A. DATE REC'D BY HEALTH DEPT

JAN 7 1972

25B. NAME OF REGISTRAR

D. E. J. J. J.

25C. FUNERAL DIRECTOR

R. D. Pollick 2431 E. Oliver St.

ADDRESS

• T C H E •

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">72 00140</span>	
BIRTH NO. <span style="float: right;">72 00140</span>		1. NAME OF DECEASED (Type or Print) <u>Rudolph F. Everhardt</u>		2. DATE AND HOUR OF DEATH <u>1-6-72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>00 HOME</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>3129 EASTERN AVE</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>102</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3129 EASTERN AVE</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-1898</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PRINTER</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>CHARLES EVERHARDT</u>			14. MOTHER'S MAIDEN NAME <u>CATHERINE CAHUL</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES 4-10-17 12-31-19</u>		16. SOCIAL SECURITY NO. <u>577-10-1034</u>	17. INFORMANT <u>CHARLES R. EVERHARDT</u> ADDRESS <u>3427 EIMLEY AVE</u>		
18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cumy Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Emphysema</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> 19 <u>64</u> to <u>1/6</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>12/15</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Julius H Goodman MD</u>			23B. DATE SIGNED <u>1/7/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Julius H Goodman MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-10-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	
24D. LOCATION (City, town, or county) (State) <u>7225 EASTERN AVE MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>		25C. FUNERAL DIRECTOR <u>LOVAT &amp; ZIEGLER INC. 1901 EASTERN AVE</u>			

100-100000

100-100000

100-100000

100-100000

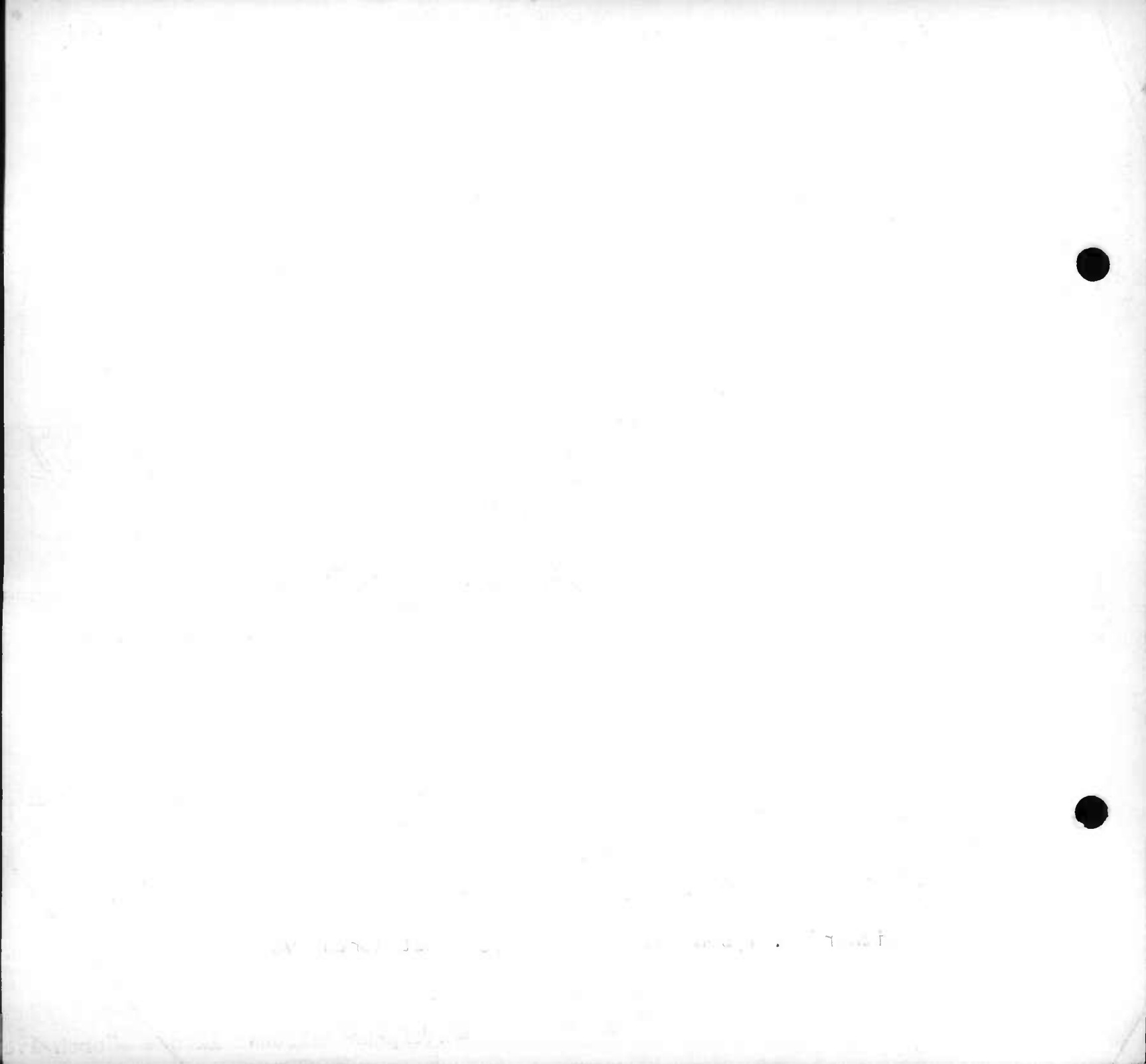
100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00141</u>	
4-610 72 00141		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Maggie HARVEY</u>		2. DATE AND HOUR OF DEATH <u>1/3/72</u> <u>10:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>CHARLES</u> <u>5800</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nursing Home</u>		C. CITY OR TOWN <u>La Plate</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F.</u> 6. RACE <u>negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-86</u>		9. AGE (in years last birthday) <u>85</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer &amp; domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
13. FATHER'S NAME <u>ALston,</u>		14. MOTHER'S MAIDEN NAME <u>Keyy</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-54-6776</u>		17. INFORMANT <u>Chart</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Hypostatic Pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Cardiovascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arteriosclerosis</u> (C) <u>Chronic Brain Syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u> <u>7 yrs.</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8 MAY</u> 19 <u>65</u> to <u>3 JAN</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3 Jan</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard F. Tyson, MD.</u>		23B. DATE SIGNED <u>1-3-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard F. Tyson MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>M. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>			
25D. ADDRESS <u>1206 W North Ave</u>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <u>72 00142</u></p>	
<p>BIRTH NO. <u>S-532</u> <u>72 00142</u></p>			
<p>1. NAME OF DECEASED (Type or Print) <u>SHANDS, LENNON</u></p>		<p>2. DATE AND HOUR OF DEATH <u>JAN. 1, 1972</u> <u>10:25A.M.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL BALTIMORE</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> <u>1512</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3906 GREENSPRING AVE.</u></p>	
<p>5. SEX <u>M</u></p>	<p>6. RACE <u>N</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>10/10/13</u></p>
<p>9. AGE (In years last birthday) <u>58</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Handler</u></p>	<p>11. BIRTHPLACE (State or foreign country) <u>Virginia</u></p>
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>Anthony Shands</u></p>	
<p>14. MOTHER'S MAIDEN NAME <u>Armeda Harville</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>	
<p>16. SOCIAL SECURITY NO. <u>216-10-2648</u></p>		<p>17. INFORMANT <u>Mrs. Verna Shands</u> ADDRESS <u>3906 Greenspring Ave.</u></p>	
<p>18. <u>431.014250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>MASSIVE BRAIN STEM HEMORRHAGE</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSION</u> <u>DIABETES MELLITUS</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p>19. DATE OF OPERATION <u>0</u></p>		<p>20. AUTOPSY? (Yes or No) <u>NO</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>INJURY OCCUR?</u> (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>12/1/71</u></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR? <u>12/1/71</u></p>		<p>22. I certify that <u>(this hospital)</u> attended the deceased from <u>12/12/71</u> 19 to <u>1/1/72</u> 19 that <u>(we)</u> last saw the deceased alive on <u>12/1/71</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE <u>Armando C. Diamco, M.D.</u></p>		<p>23B. DATE SIGNED <u>JAN. 1, 1972</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>ARMANDO C. DIAMCO, M.D.</u></p>		<p>23D. ADDRESS <u>SINAI HOSPITAL BALTIMORE</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>1-5-72</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn Cem</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Westport Md</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Kelly, R.D.</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Joseph L. Purn</u></p>		<p>ADDRESS <u>2222 W. North Ave</u></p>	

Handwritten text at the bottom of the page, likely a signature or date, appearing as "1954" and "1955".

BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

**1. NAME OF DECEASED**  
 (Type or Print) Carolyn E. Kenny Howerton

**2. DATE OF DEATH**  
 Known ☒ Estimated ☐  
 Month Day Year Hour  
1 4 72 4:45 A. M.

**3. DATE PRONOUNCED DEAD**  
 Month Day Year Hour  
1 4 72 4:45 A. M.

**4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**  
 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
34 Bon Secours Hospital

**5. USUAL RESIDENCE** (Where deceased lived, if institution: residence before admission)  
 A. STATE Maryland B. COUNTY 1506

**6. SEX** Female **7. RACE** Negro **8. MARRIED** ☐ **NEVER MARRIED** ☐  
**WIDOWED** ☐ **DIVORCED** ☐

**9. DATE OF BIRTH** Sept. 18 1947 **10. AGE** (In years last birthday) 24  
 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

**11. BIRTHPLACE** (State or foreign country) Baltimore Md **12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME** James R. Kenny

**14. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Housewife **15. MOTHER'S MAIDEN NAME** Sarah Grant

**16. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes, give war or dates of service) **17. SOCIAL SECURITY NO.** **18. INFORMANT** Mrs. Sarah Kenny 2826 W. Stwood Av

**19. CAUSE OF DEATH**  
E 890X  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
**ANTECEDENT CAUSES**  
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).**

**(A) IMMEDIATE CAUSE** Smoke and soot inhalation  
 DUE TO, OR AS A CONSEQUENCE OF:  
**(B)** DUE TO, OR AS A CONSEQUENCE OF:  
**(C)** DUE TO, OR AS A CONSEQUENCE OF:

**APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH**

**20A. DATE OF OPERATION** 2 **20B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **21. AUTOPSY?** (Yes or No) Yes

**22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.** **22B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) House **22C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location) 1419 W. Mulberry Street

**22D. TIME OF INJURY** (Month) (Day) (Year) (Hour) (APPROX.) 1 4 72 3:55A. **22E. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☒ **22F. HOW DID INJURY OCCUR?** (smoking in bed) incident to conflagration

**23.**  
 I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

**ACTUAL SIGNATURE** Werner U. Spitz **Deputy CHIEF MEDICAL EXAMINER** ☒  
**EXAMINER'S NAME** (Type) Werner U. Spitz, M.D. **ASSISTANT MEDICAL EXAMINER** ☐  
**ASSOCIATE MEDICAL EXAMINER** ☐ **DATE SIGNED** 1-4-72

**24A. BURIAL CREMATION, REMOVAL** (Specify) Burial **24B. DATE** Jan. 8 1971 **24C. NAME OF CEMETERY or CREMATORY** Arbutus Men. Cem. **24D. LOCATION** (City, town, or county) (State) ARBUTUS MD

**25A. DATE REC'D BY HEALTH DEPT.** JAN 7 1972 **25B. NAME OF REGISTRAR** Joseph L. Russ **25C. FUNERAL DIRECTOR** JOSEPH L. RUSS 2222 W. NORTH AVE

13 0013

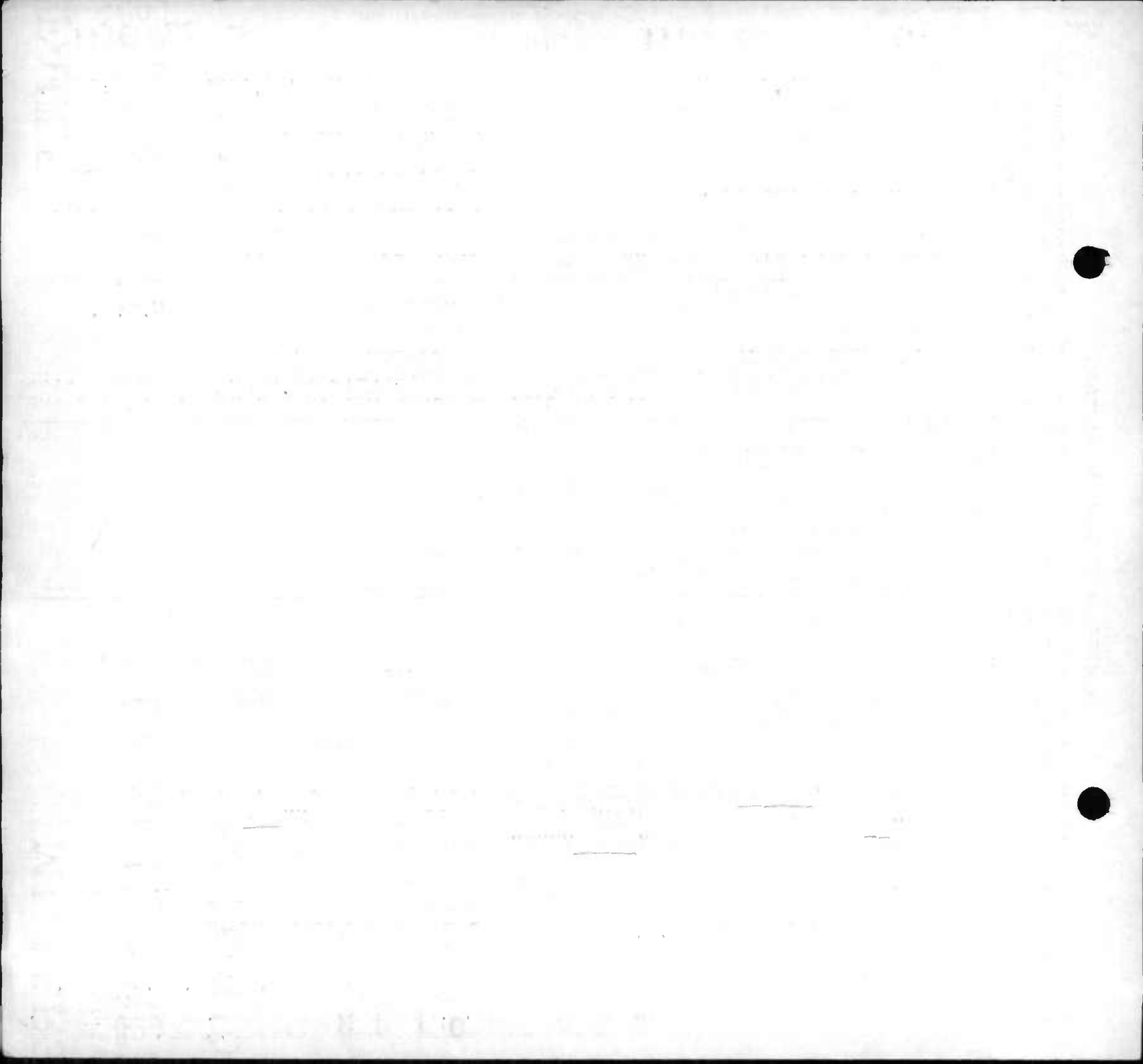
13 0013

MAK

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00144	
BIRTH NO. K-540		72 00144		72 00144			
1. NAME OF DECEASED (Type or Print) KNELL, GERTRUDE EMMA				2. DATE AND HOUR OF DEATH JANUARY 6, 1972 8:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2637 TURF VALLEY ROAD 21043			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/28/00	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLEAMENS KARFGIN				14. MOTHER'S MAIDEN NAME GERTRUDE ESSELMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 220 48 0673		17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac shock ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute anteroseptal myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: 1 day (C) Rheumatoid arthritis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month) 1 Day) 1 Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JANUARY 6 1972 to JANUARY 6 1972 that (X) (we) last saw the deceased alive on JANUARY 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED 01 07 72			
23C. PHYSICIAN'S NAME (Type) JOSE APTER M.D. DEGREE				23D. ADDRESS CATON & WILKENS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/8/72		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto., Md. 21212			

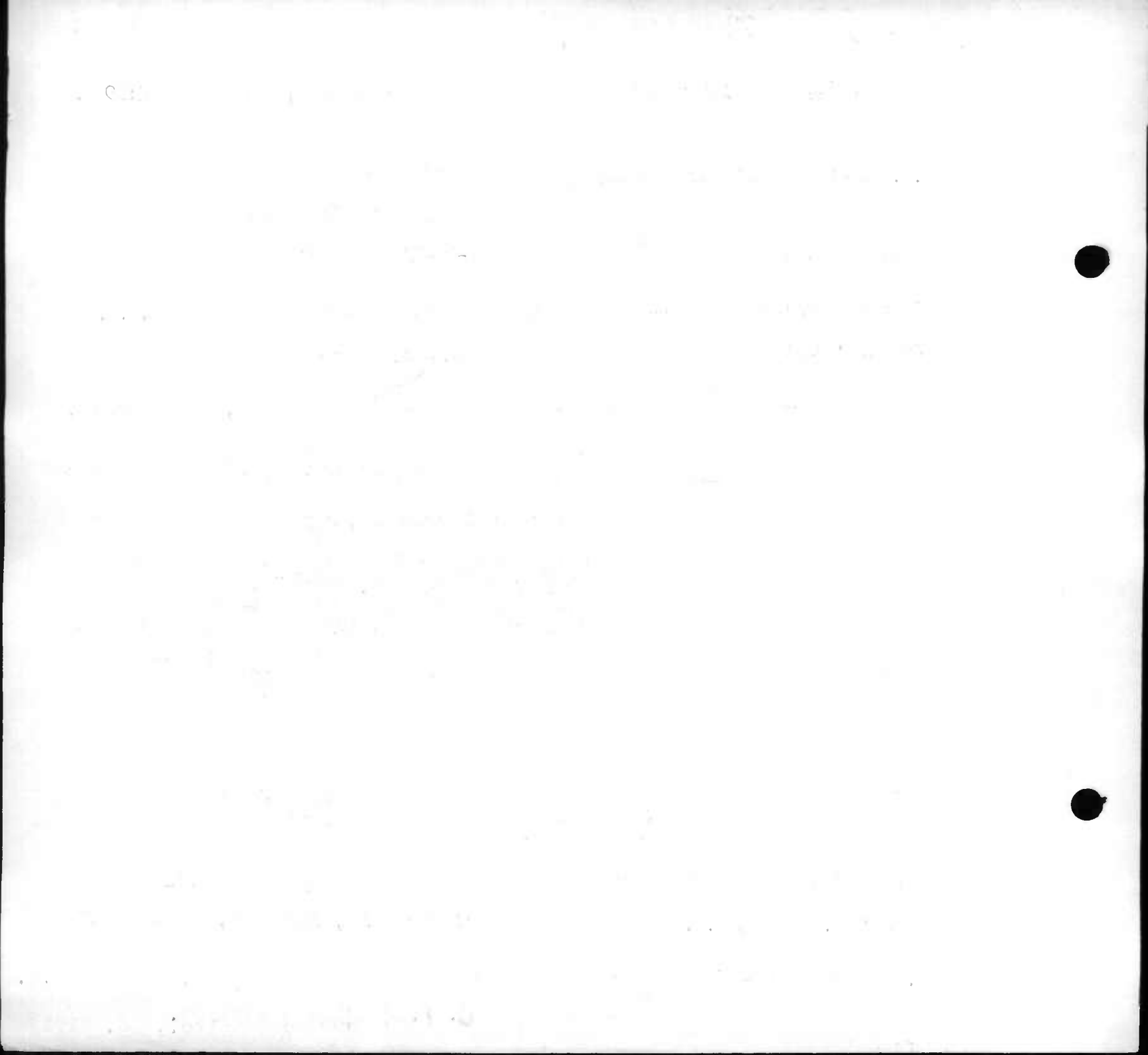


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

bvs

H-400		72 00145		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00145	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Hall, Mary Sylvia Herbst</b>				2. DATE AND HOUR OF DEATH <b>January 6, 1972 4:30 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>U.S. PUBLIC HEALTH SERVICE HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ohio</b> B. COUNTY <b>V32</b>				C. CITY OR TOWN <b>Rocky River</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>5-21-23</b> 9. AGE (in years last birthday) <b>48</b>				If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guidance Counselor</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Education</b>				11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Julius T Herbst</b>				14. MOTHER'S MAIDEN NAME <b>Taylor, Rebecca</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>225 28 0815</b>				17. INFORMANT ADDRESS <b>RECORDS- US PHS HOSPITAL, Baltimore, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute bilateral bronchopneumonia with pulmonary infarction, multiple</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? one week</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic pyelonephritis, right cystitis</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Partial small bowel obstruction with peritoneal metastases &amp; intestinal adhesions.</b>				unknown weeks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Metastatic serous papillary cyst-adenocarcinoma of the ovary</b>								4 years	
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>November 29 1971</b> to <b>January 6 1972</b> that (X) (we) last saw the deceased alive on <b>January 6 1972</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert R. Wright, M.D.</b>				23B. DATE SIGNED <b>1-6-72</b>				23C. PHYSICIAN'S NAME (Type) <b>Robert R. Wright, M.D.</b>	
23D. ADDRESS <b>US PHS HOSPITAL, Baltimore, Maryland 21211</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>				24B. DATE <b>1-9-72</b>				24C. NAME of CEMETERY or CREMATORY <b>Oleander Memorial Gardens</b>	
24D. LOCATION (City, town, or county) (State) <b>Wilmington, N.C.</b>									
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>				25B. NAME of REGISTRAR <b>0 0 0 0 0 0</b>				25C. FUNERAL DIRECTOR ADDRESS <b>O. V. Jenkins &amp; Sons Co. 1903 York Road Balto., Md. 21212</b>	

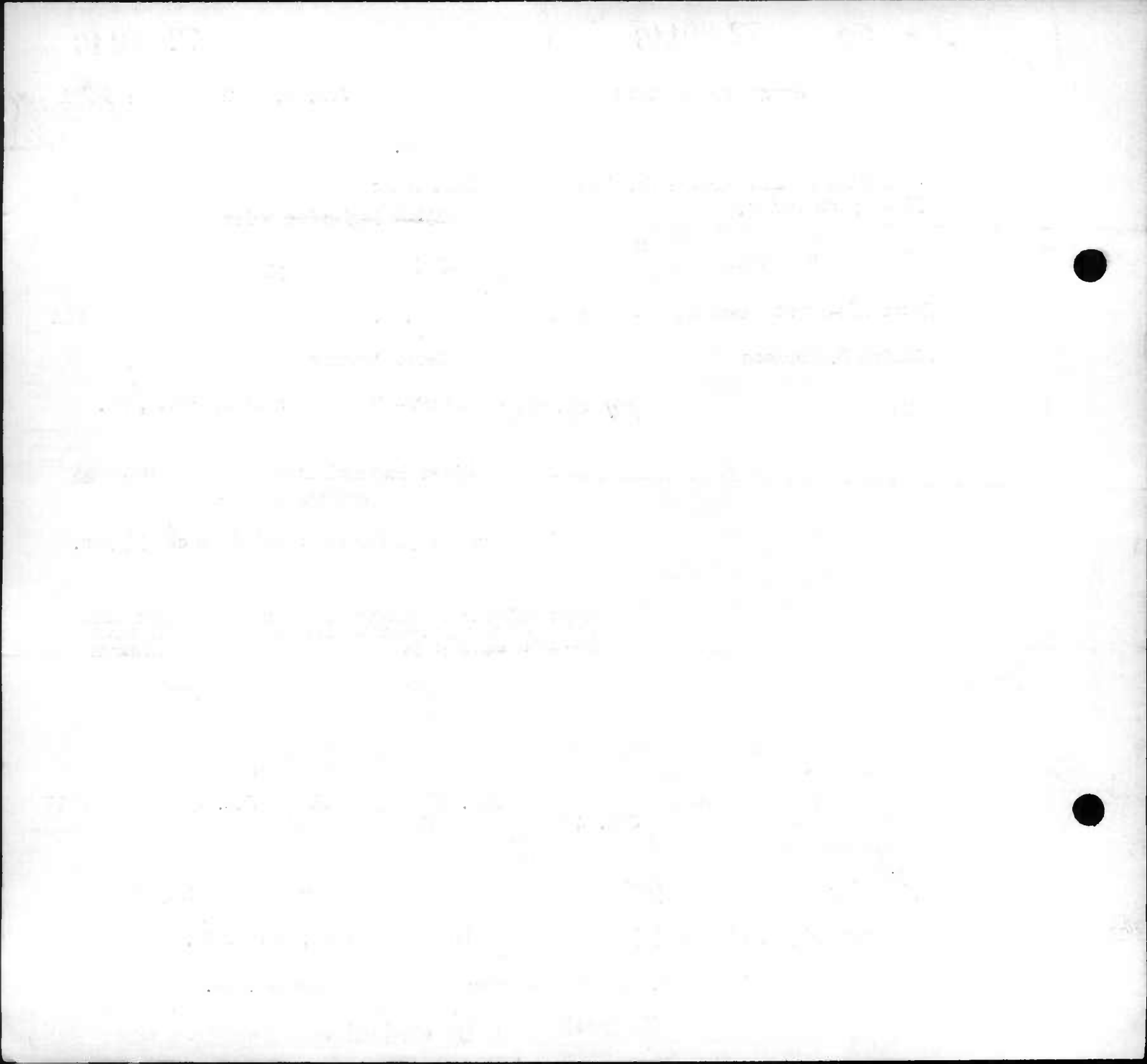




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

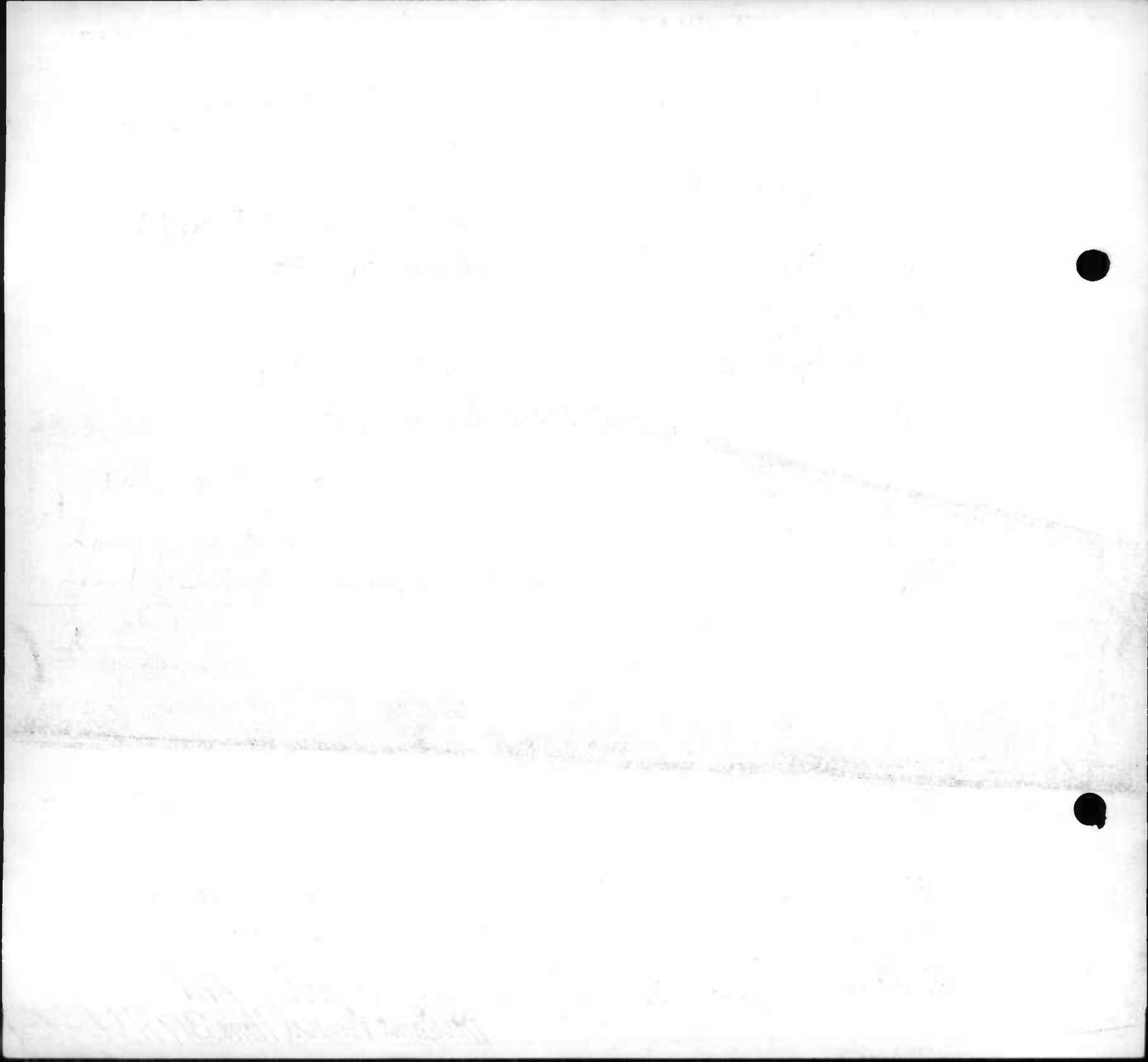
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00146</span>	
BIRTH NO. <span style="float: right;">72 00146</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Nancy Ann Di Biase</span>			2. DATE AND HOUR OF DEATH Jan. 4, 1972 12:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">P.G. 6600</span> C. CITY OR TOWN <span style="float: right;">Beltsville</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="float: right;">13207 Ingleside Drive</span>		
5. SEX F	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/40	9. AGE (In years last birthday) 31	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Nurse Instructor - Education			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William R. Harless		
14. MOTHER'S MAIDEN NAME Naomi Watters			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 191-32-5867			17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Right temporal lobe DUE TO, OR AS A CONSEQUENCE OF: herniation of brain  (B) Right frontal glioblastoma multiforme DUE TO, OR AS A CONSEQUENCE OF:  (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal			3 1/2 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute bilateral bronchopneumonia Chronic urinary tract infection <del>Possible septicemia</del>			One week Unknown Unknown		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 9</u> 19 <u>71</u> to <u>Jan. 4</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan. 4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert P. Wright, MD</i>			23B. DATE SIGNED 1/4/72		23C. PHYSICIAN'S NAME (Type) Robert Wright, SA Surg (R)
23D. ADDRESS US PHS Hospital, Balto, Md.			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 1/7/72		24C. NAME OF CEMETERY or CREMATORY Ft. Lincoln Cemetery		24D. LOCATION (City, town, or county) (State) Bladensburg, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR E. J. ...		25C. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS INC. 130 WISE AVE. N. W. WASH. D. C. 20016	



**FUNERAL DIRECTOR: IMPORTANT**

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L-220		72 00147		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00147	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <b>Eugene Ford Lykes</b>				2. DATE AND HOUR OF DEATH <b>Jan. 5, 1972 1:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital 38</b>				A. STATE <b>MD.</b> B. COUNTY <b>Balt.</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>812 W. Lexington St. Apt 6</b>			
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-2-01</b>	9. AGE (in years last birthday) <b>70</b>	10. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Parking lot Attendant</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
13. FATHER'S NAME <b>Fred Lykes</b>				14. MOTHER'S MAIDEN NAME <b>Nellie - Wright</b>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-05424</b>		17. INFORMANT <b>Hilda Lykes</b>	
18. CAUSE OF DEATH <b>410.91</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypoxic Brain Damage</b>		<b>1 week</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Ventricular Fibrillation</b>		<b>1 week</b>	
				(C) <b>Acute Myocardial Infarction</b>		<b>1 week</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>10-9-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1, 1972</b> to <b>Jan. 5, 1972</b> and that (I) (we) last saw the deceased alive on <b>Jan. 5, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stephen Greenberg M.D.</b>				23B. DATE SIGNED <b>1/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Stephen Greenberg</b>	
23D. ADDRESS <b>University Hospital</b>				23E. CITY OR TOWN <b>Baltimore</b>		23F. STATE <b>MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/8/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Balto. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. ...</b>		25C. FUNERAL DIRECTOR <b>William's Funeral Home</b>		25D. ADDRESS <b>319 N. ...</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ERNEST FRASIER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year <b>January 4, 1972</b> Hour <b>2:30 P.</b> M.			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>JAN 29 1903</b>				10. AGE (In years last birthday) <b>68</b>		11. BIRTHPLACE (State or foreign country) <b>Winnstonboro S.C.</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Samuel Frazier</b>		14. MOTHER'S MAIDEN NAME <b>Annora Wright</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ground Keeper</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
17. SOCIAL SECURITY NO. <b>214-12-1480</b>				18. INFORMANT <b>Olga Kinyard</b> ADDRESS <b>1316 Riggs Ave</b>			
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>No</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/5/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Old National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [unclear]</b>		25C. FUNERAL DIRECTOR <b>William [unclear]</b>		ADDRESS <b>319 N. [unclear]</b>	

1. Name of the person or persons to whom the land is being conveyed: [illegible]

2. Name of the person or persons from whom the land is being conveyed: [illegible]

3. Description of the land: [illegible]

4. Date of the conveyance: [illegible]

5. Signature of the person or persons to whom the land is being conveyed: [illegible]

6. Signature of the person or persons from whom the land is being conveyed: [illegible]

7. Signature of the person or persons who are witnesses to the conveyance: [illegible]

8. Signature of the person or persons who are witnesses to the conveyance: [illegible]

9. Signature of the person or persons who are witnesses to the conveyance: [illegible]

10. Signature of the person or persons who are witnesses to the conveyance: [illegible]

11. Signature of the person or persons who are witnesses to the conveyance: [illegible]

12. Signature of the person or persons who are witnesses to the conveyance: [illegible]

13. Signature of the person or persons who are witnesses to the conveyance: [illegible]

14. Signature of the person or persons who are witnesses to the conveyance: [illegible]

15. Signature of the person or persons who are witnesses to the conveyance: [illegible]

16. Signature of the person or persons who are witnesses to the conveyance: [illegible]

17. Signature of the person or persons who are witnesses to the conveyance: [illegible]

18. Signature of the person or persons who are witnesses to the conveyance: [illegible]

19. Signature of the person or persons who are witnesses to the conveyance: [illegible]

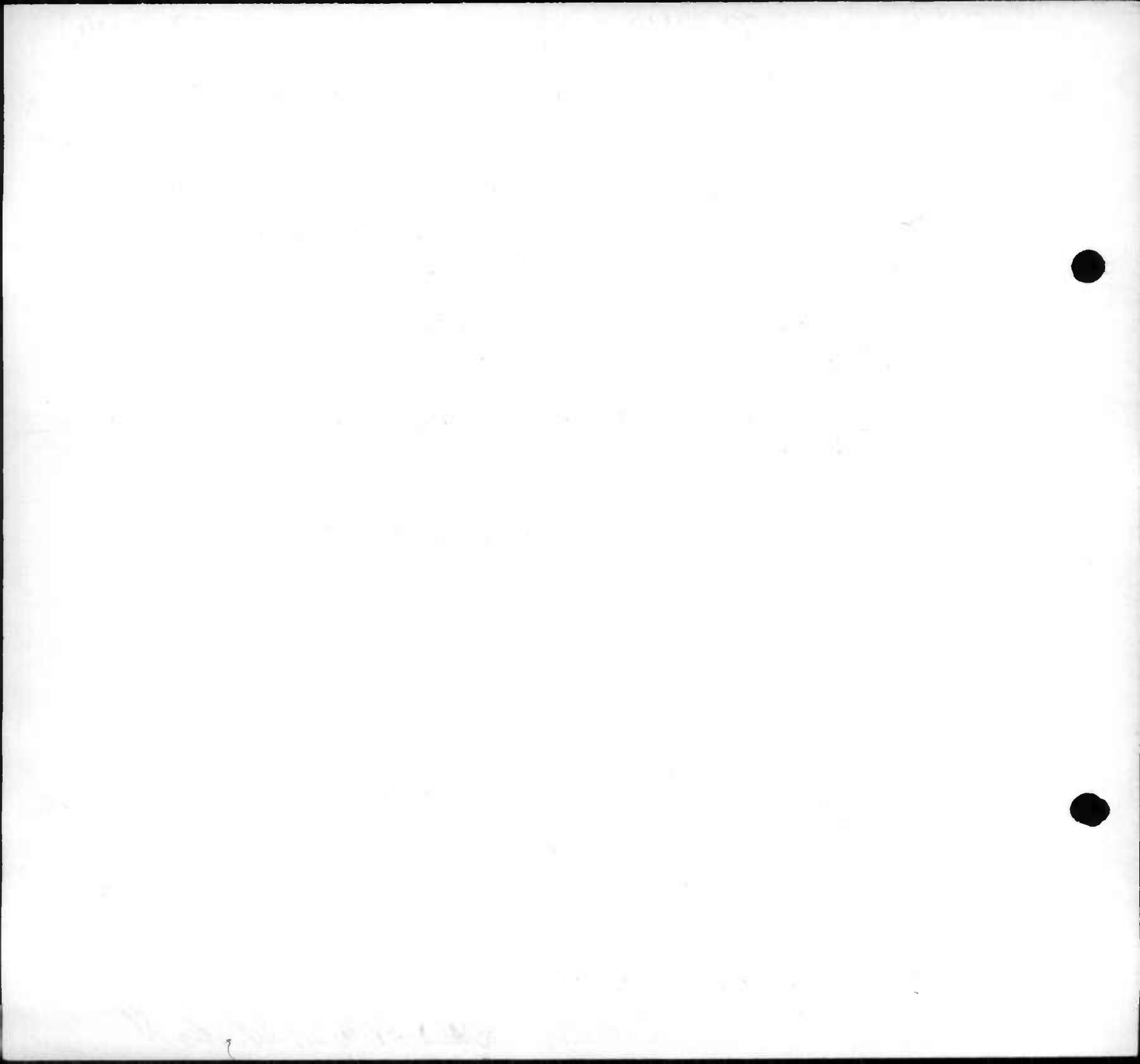
20. Signature of the person or persons who are witnesses to the conveyance: [illegible]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		72 00149		BALTIMORE CITY HEALTH DEPARTMENT		72 00149	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print) <b>PRICE, BERNARD</b>				2. DATE AND HOUR OF DEATH <b>1-4-72 3:55 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b>				A. STATE <b>MD</b> B. COUNTY <b>1547</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE MD</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2108 ROSEDALE ST</b>							
5. SEX <b>MALE</b>	6. RACE <b>NEIRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-8-16</b>		9. AGE (in years last birthday) <b>55</b>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pisgh MD</b>	
13. FATHER'S NAME <b>Robert Price</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Gray</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>215-03240</b>		17. INFORMANT <b>Laurette Smith Box 135 Pisgh MD</b>		ADDRESS	
18. <b>403X I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1) REMIA</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>C.V.A.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>12-25-71</b> to <b>1-4-72</b> that (1) (we) last saw the deceased alive on <b>1-4-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Atiaz Arain M.D.</b>				23B. DATE SIGNED <b>1-4-72</b>		23C. PHYSICIAN'S NAME (Type) <b>ATIAZ ARAIN M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/8/72</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Luke's Cemetery</b>	
24D. LOCATION <b>Balto. MD</b>				24E. LOCATION (City, town, or county) (State) <b>Balto. MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Reuben E. Taylor</b>		25C. FUNERAL DIRECTOR <b>William F. D. 319</b>		ADDRESS <b>Salvador St.</b>	

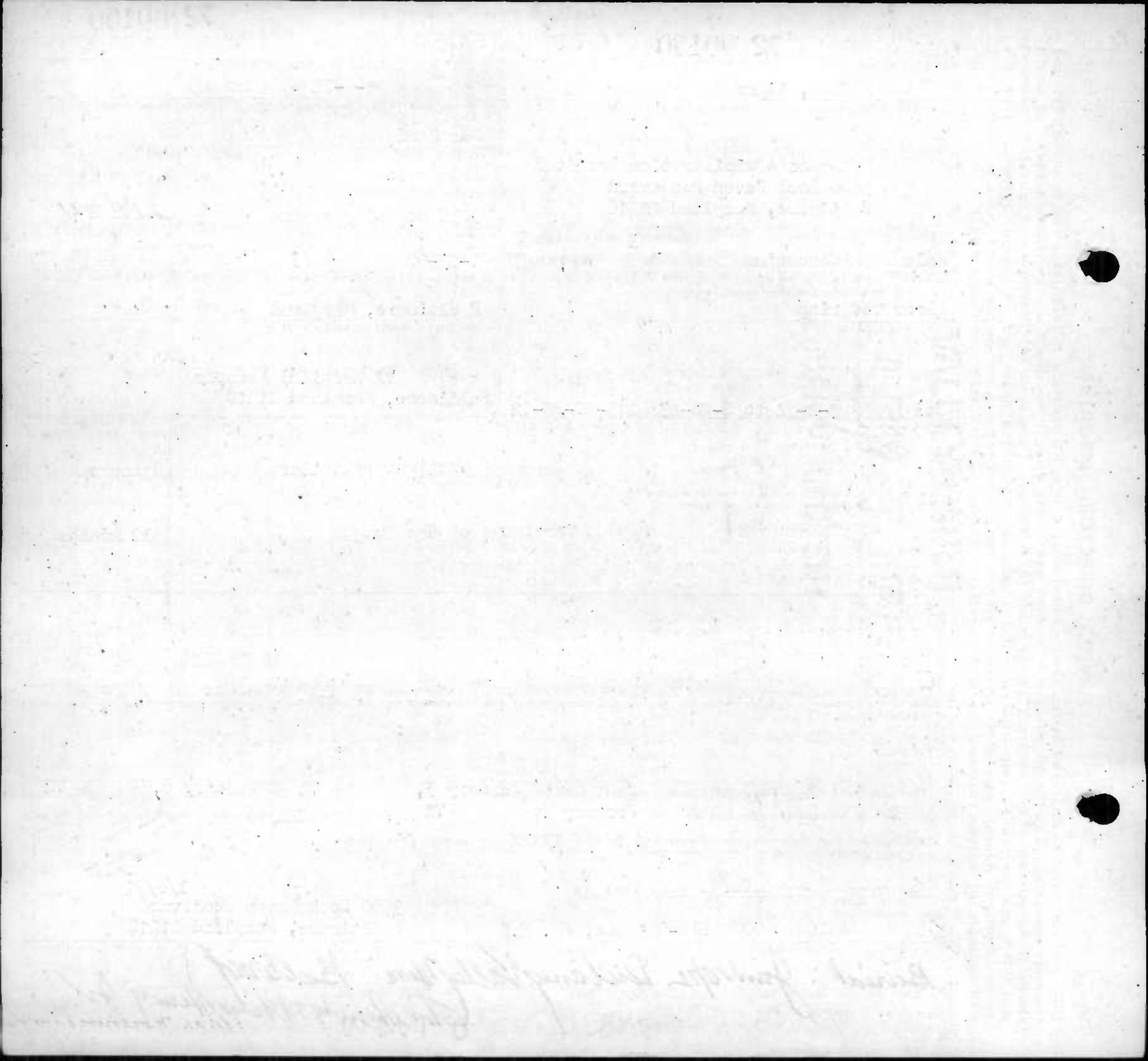




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00150		REG. NO.	
BIRTH NO. 72 00150				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>REGNER, Edgar G</b>				2. DATE AND HOUR OF DEATH 1-6-72 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital</b> 3900 Loch Raven Boulevard Baltimore, Maryland 21218				A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3038 Woodside Avenue</b> 21234			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-08</b>	9. AGE (In years last birthday) <b>63</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Covering</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Covering</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-9-44 to 8-28-45</b>				16. SOCIAL SECURITY NO. <b>219-20-85-12</b>		17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>8 hours</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Carcinoma of the lung</b> DUE TO, OR AS A CONSEQUENCE OF: <b>12 months</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 5, 1972</b> to <b>January 6, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 6, 1972</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>not</b> view the body after death.							
23A. SIGNATURE <b>Antonio Gonzalez-Revilla, Jr.</b>				23B. DATE SIGNED <b>1/6/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ANTONIO GONZALEZ-REVILLA, JR. M.D.</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>Jan 7 1972</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Greenwood Valley Home</b>			
24D. LOCATION <b>Baltimore</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>			
25B. NAME OF REGISTRAR <b>John Henry</b>				25C. FUNERAL DIRECTOR <b>John Henry</b>			
25D. ADDRESS <b>4406 Northern Hwy</b>				25E. ADDRESS <b>21206</b>			



P-200

72 00151

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

X 72 00151  
REG. NO.

BIRTH NO.

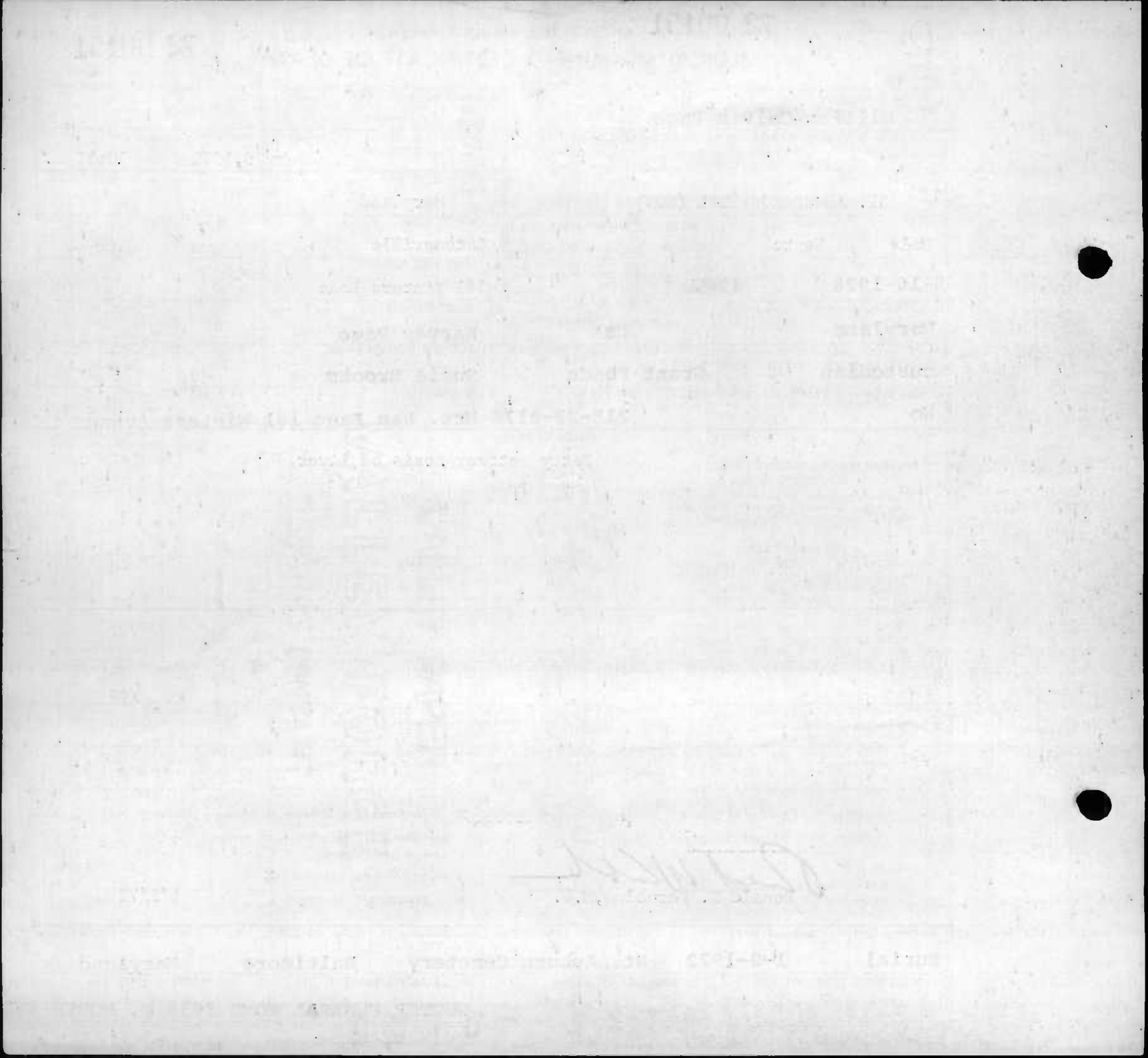
1. NAME OF DECEASED (Type or Print) <b>William Calvin Page</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>January 5, 1972 10:30 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Catonsville</b>	
9. DATE OF BIRTH <b>5-10-1928</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harvey Page</b>		14. MOTHER'S MAIDEN NAME <b>Susie Brooks</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>custodian</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Grant Foods</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>215-22-9176</b>	
19. INFORMANT <b>Mrs. Nan Page</b>		ADDRESS <b>181 Winters Avenue</b>	

19. <b>571.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Fatty metamorphosis of liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED: <b>1/5/72</b>					
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--	--	--

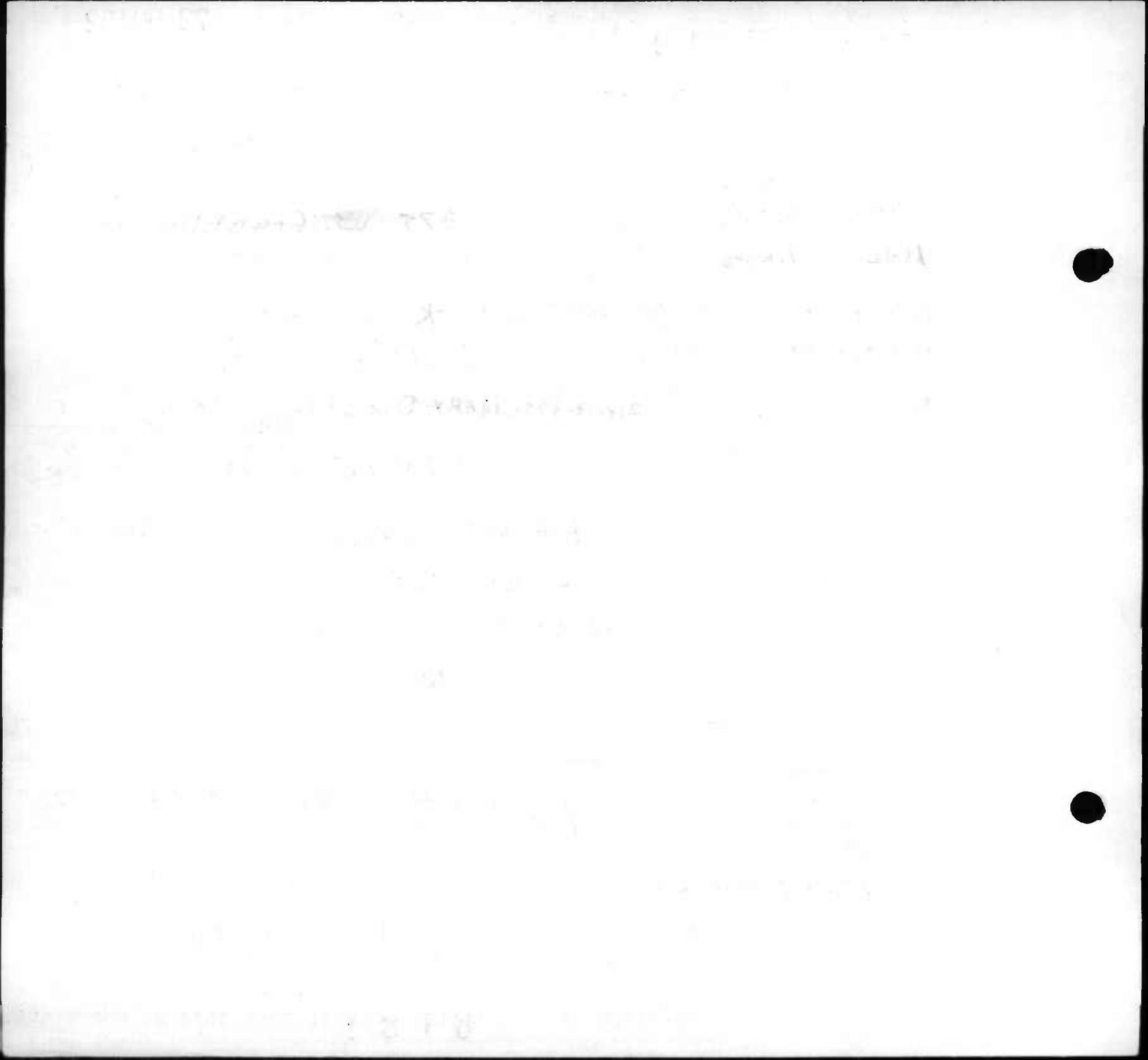
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-8-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AVE</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-200 72 00152		BALTIMORE CITY HEALTH DEPARTMENT		72 00152	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
DIX, WILL		7:30 pm 1/4/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
UNIVERSITY of MD. BALTIMORE.		MD BALTIMORE 1701			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALT.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		675 W. Franklin St.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-6-08	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER		CONSTRUCTION		PARLEY, Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HENRY DIX		LULA WHITE		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		218-18-8750		MARY DIX 675 W. FRANKLIN & BALTIMORE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
250.91		STROKE - CVA		7 weeks	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) ATHEROSCLEROSIS		Many years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DIABETES		8 years	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		3 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/21 1971 to 1/4 1972 that (I) (we) last saw the deceased alive on 1/4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Paul East		1/4/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PAUL EAST		U. of MD. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-8-1972		Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 7 1972		Robert E. Taylor, M.D.		NUTTER FUNERAL HOME 3035 W. NORTH AVE.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00153	
J-520 72 00153		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>James L. Jones</b>		2. DATE AND HOUR OF DEATH <b>1/6/1972 15.20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; Hospital 100 N. Broadway BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>M.D.</b> B. COUNTY <b>HOWARD</b> C. CITY OR TOWN <b>HANOVER</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Box 39B Wrights Road</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-1930</b>		9. AGE (in years last birthday) <b>41</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Department of Defense</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Jones</b>			
14. MOTHER'S MAIDEN NAME <b>Rosa Miller</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Korean</b>			
16. SOCIAL SECURITY NO. <b>229-26-3247</b>		17. INFORMANT ADDRESS <b>Mrs. Laverna H. Jones Box 39B Wrights</b>			
18. <b>189.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Not definite</b> DUE TO, OR AS A CONSEQUENCE OF: <b>'Ca' (R) kidney.</b> (B) <b>Unknown.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1. 3. 1972</b> to <b>1. 6. 1972</b> that (I) (we) last saw the deceased alive on <b>1. 6. 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Satpal Singh</b>		23B. DATE SIGNED <b>1. 6. 72</b>			
23C. PHYSICIAN'S NAME (Type) <b>SATPAL SINGH</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-10-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Laurel</b>		24E. STATE <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. Smith</b>		25C. FUNERAL DIRECTOR ADDRESS <b>NOTTER FUNERAL HOME 3035 W. NORTH AVE.</b>	

Mr. J. M. Jones

7-11-1950

Virginia

Rocky Mountain

120-26-1247 Mrs. J. M. Jones



G-650

72 00154

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00154

BIRTH NO.

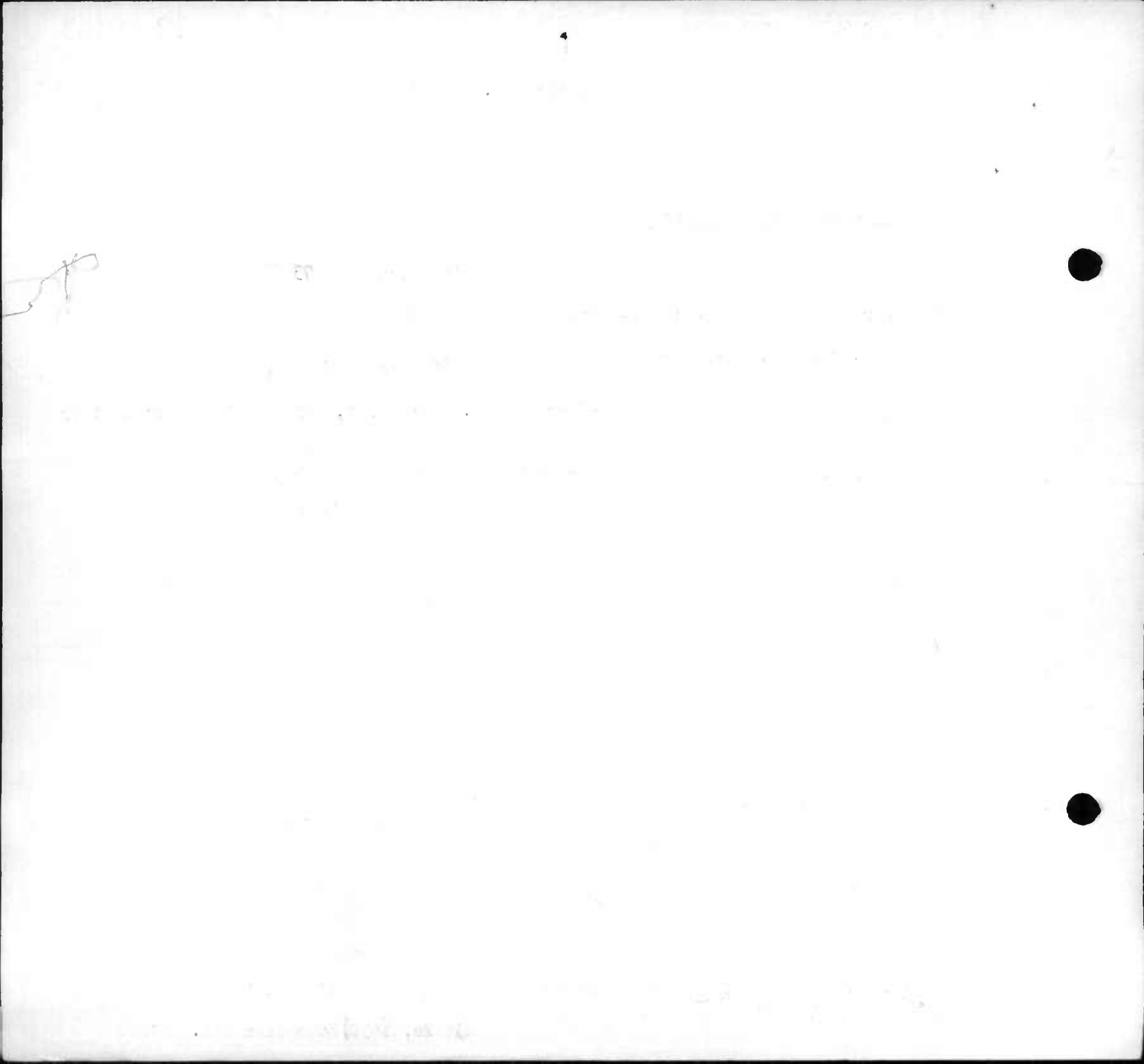
1. NAME OF DECEASED (Type or Print) Elizabeth Graham		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 1	Day 6	Year 72	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD		Month 1	Day 6	Year 72	Hour 4:05 p.	M.
6. SEX female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1303		
9. DATE OF BIRTH 7-8-1905		10. AGE (In years last birthday) 66		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Farmer Willis		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME ? Baytop		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		
17. SOCIAL SECURITY NO. 217-34-2930		18. INFORMANT Mr. William A. Graham		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION 0		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-10-1972		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 7 1972		24F. NAME OF REGISTRAR Robert E. [Signature]		24G. FUNERAL DIRECTOR NUTTER FUNERAL HOME		24H. ADDRESS 3035 W. NORTH AV

*Handwritten signature*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-655 72 00155		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00155	
1. NAME OF DECEASED (Type or Print) <b>ANGELK BROENING (Angela M. Broening)</b>		2. DATE AND HOUR OF DEATH <b>1/7/72 11:59 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Md GEN Hosp Maryland General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1201</b>			
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/17/1898</b>		9. AGE (In years last birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Late Jacob Broening</b>		14. MOTHER'S MAIDEN NAME <b>Late Mary Kney</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-32-8148</b>		17. INFORMANT <b>Mr. John Dolle, 813 Branford Circle 21093</b>	
18. <b>410.91</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ABCD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1/7/72</b> 19 <b>72</b> to <b>1/7/72</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>1/7/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bayani B. Elma M.P.</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>BAYANI B. ELMA M.P.</b>	
23D. ADDRESS <b>5355 Carriage Ct Balto Md</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/10/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Edmondson</b>		25C. FUNERAL DIRECTOR <b>Edmondson Ave. 21228</b>	

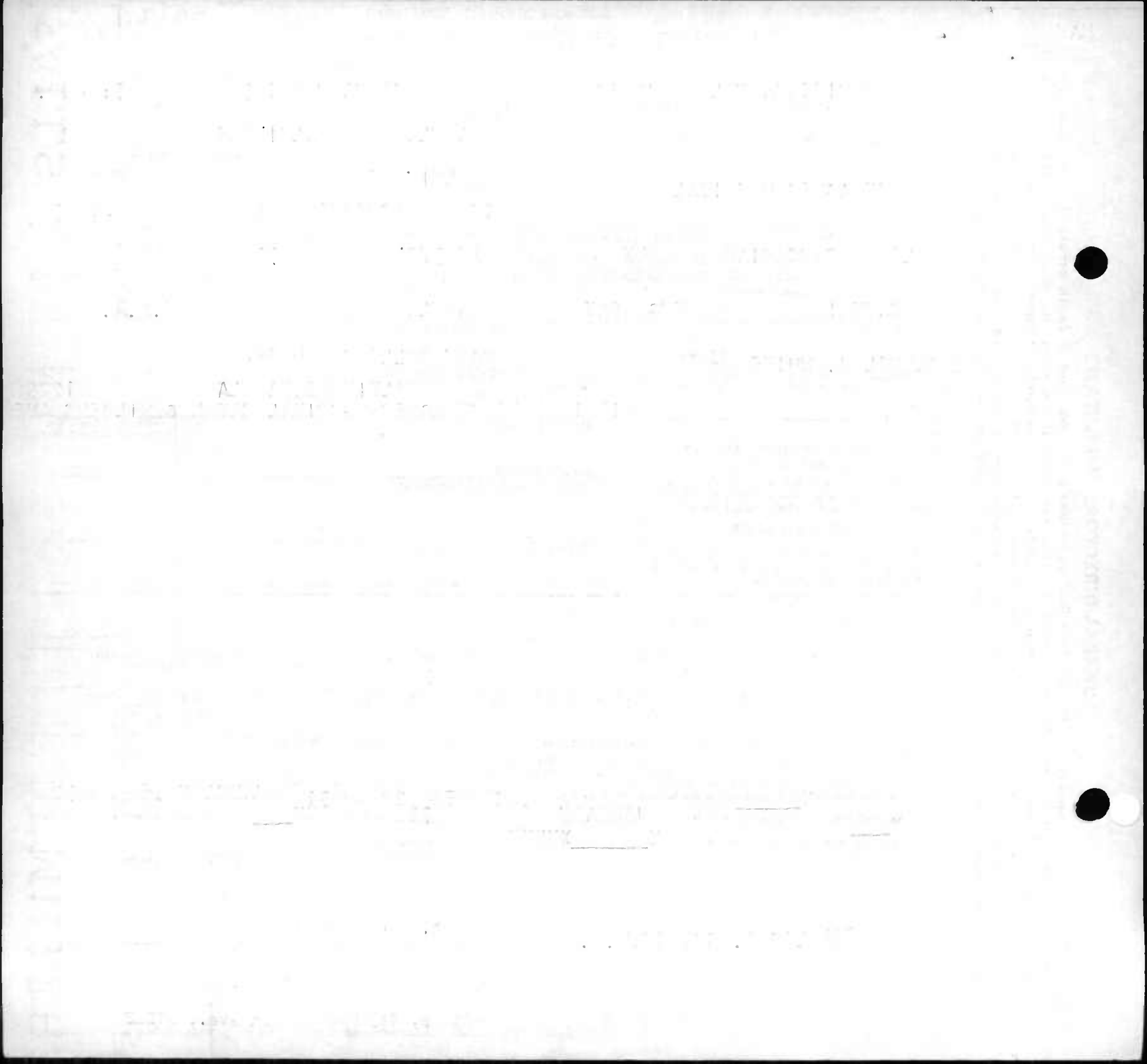


MAK

FUNERAL DIRECTOR: IMPORTANT

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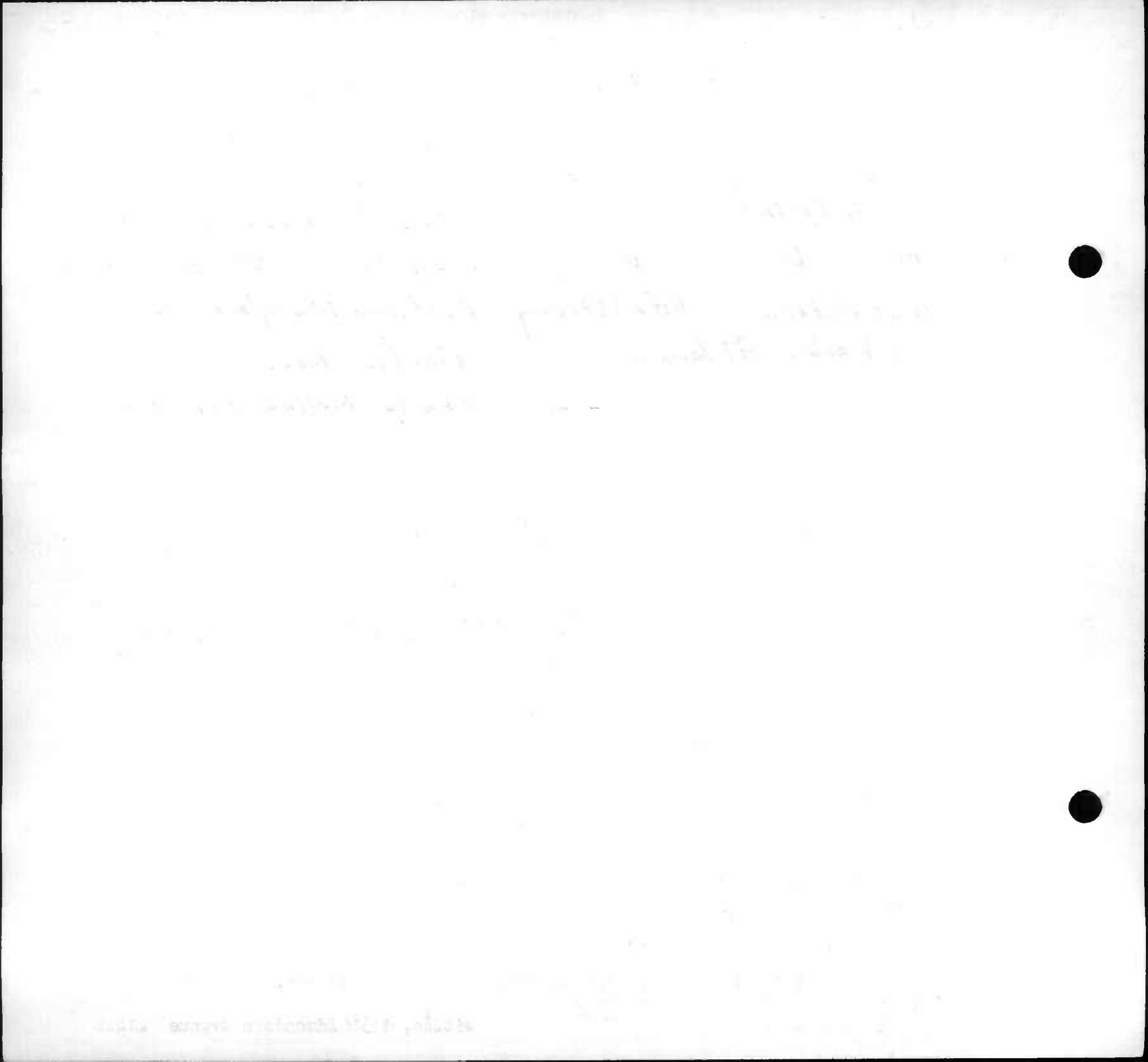
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00156	
W-300 72 00156					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) WHITE, SAMUEL JAMES			2. DATE AND HOUR OF DEATH JANUARY 6, 1972 7:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			C. CITY OR TOWN BALTIMORE D. (INSIDE CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1502 DORCHESTER ROAD 21207		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/27/94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPTAIN			10B. KIND OF BUSINESS OR INDUSTRY TUG BOAT		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME SAMUEL J. WHITE (late)		
14. MOTHER'S MAIDEN NAME MARY SOLLERS (late)			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 214 12 4846			17. INFORMANT ADDRESS BALTIMORE, MARYLAND 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 445.91 + 230.9 DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Probable C.V. A. 48 hrs.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus yrs.			(B) gangrene of lower extremities 2 months		
(C)					
19A. DATE OF OPERATION 11/29/71/12/31/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene legs		
20A. AUTOPSY (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from OCTOBER 28 1971 to JANUARY 6 1972 that (1) (we) last saw the deceased alive on JANUARY 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. R. Chaney			23B. DATE SIGNED 1/6/72		
23C. PHYSICIAN'S NAME (Type) CHARLES R. CHANEY M.D.			23D. ADDRESS St. Agnes Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/10/72		
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972			25B. NAME OF REGISTRAR R. E. Taylor Jr.		
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228			ADDRESS		



**FUNERAL DIRECTOR: IMPORTANT**

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<p><b>A-325</b>      72 00157      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00157</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Atkinson, Weller</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>1-7-72</b>      <b>5:10 P.M.</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>48 Maryland General Hospital</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b></p>	
<p><b>5. SEX</b> <b>M</b>      <b>6. RACE</b> <b>N</b></p>		<p><b>C. CITY OR TOWN</b> <b>Baltimore</b>      <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>E. STREET AND NUMBER</b> <b>5918 Channwood Road 21228</b></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ment Cutter</b></p>		<p><b>8. DATE OF BIRTH</b> <b>1-29-21</b>      <b>9. AGE</b> (In years last birthday) <b>50</b></p>	
<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Retail Grocery</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b></p>	
<p><b>13. FATHER'S NAME</b> <b>Charles Atkinson</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>218-05-1252</b></p>	
<p><b>17. INFORMANT</b> <b>Sheila Matlak</b></p>		<p><b>ADDRESS</b> <b>5918 Channwood Rd</b></p>	
<p><b>18. CAUSE OF DEATH</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration Pneumonia</b></p>		<p><b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>± 24 h.</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Liver failure - 6-I Heedlin</b></p>		<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>? 2 weeks</b></p>	
<p><b>(C) UNDERLYING CONDITION:</b> <b>Long standing</b></p>		<p><b>(D) UNDERLYING CONDITION:</b> <b>Long standing</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No)</p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Approx.)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>1/7/72</b> <b>to</b> <b>1/7/72</b> <b>that (I) (we) last saw the deceased alive on</b> <b>1/7/72</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>Victor R. Felipa M.D.</b></p>		<p><b>23B. DATE SIGNED</b> <b>1/7/72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>Victor R. FELIPA M.D.</b></p>		<p><b>23D. ADDRESS</b></p>	
<p><b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>1/11/72</b></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Memorial</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 10 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Witzke</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>Witzke</b></p>		<p><b>ADDRESS</b> <b>1638 Edmondson Avenue 21228</b></p>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

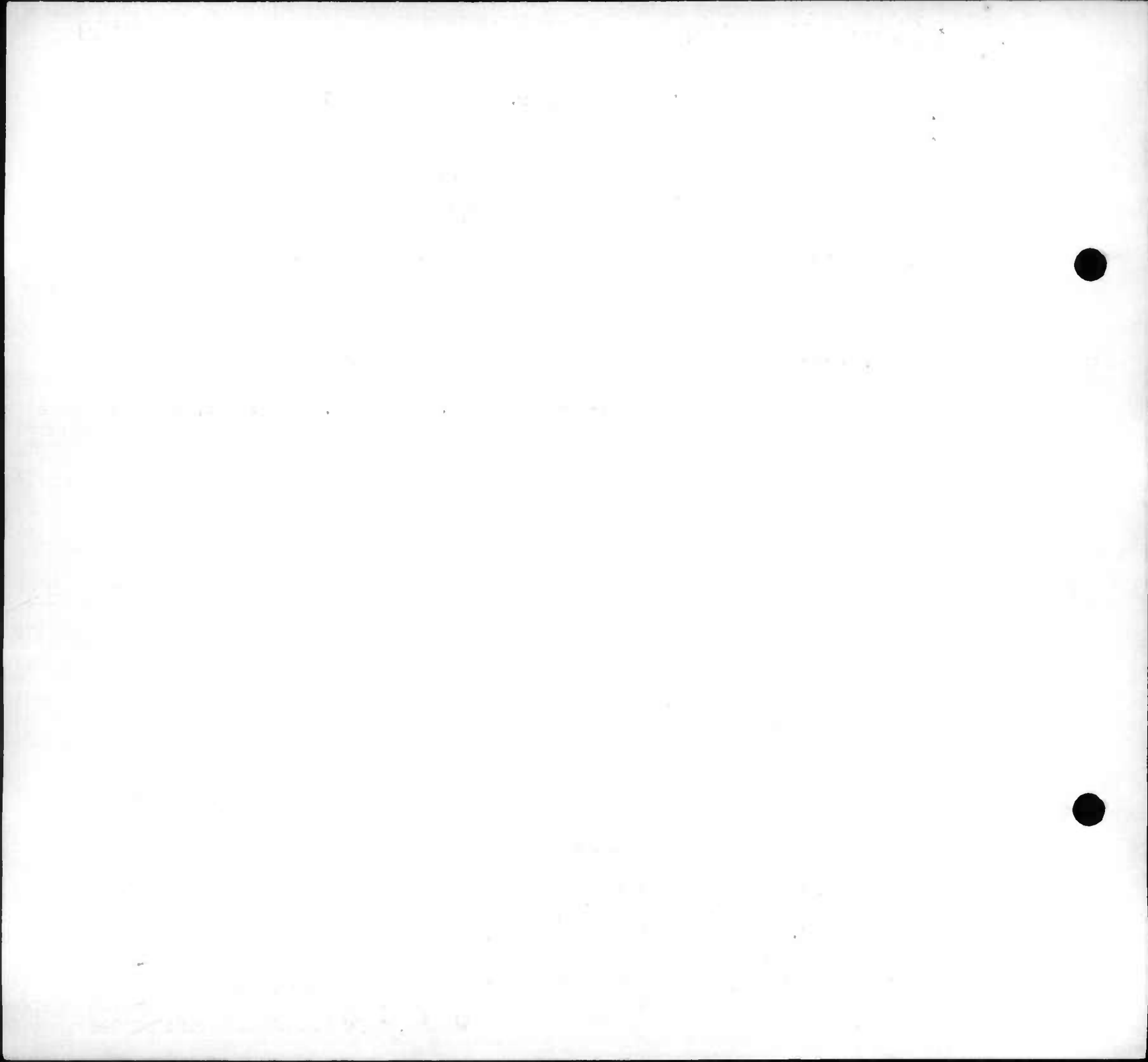
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00158	
CERTIFICATE OF DEATH					
BIRTH NO. <b>B-346</b>		1. NAME OF DECEASED (Type or Print) <b>LOUISE BUTLER</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 8 1972 5:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1307</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3939 ROLAND AVENUE</b>		
5. SEX <b>FEMME</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-86</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Receptionist</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JAMES REES</b>		14. MOTHER'S MAIDEN NAME <b>SARAA SMITH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-01-8817</b>		17. INFORMANT <b>Mrs. Louis Diven, 13 Dutton Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHO PNEUMONIA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>LEFT CEREBRAL THROMBOSIS</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>HYPERTENSION</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/24/71</b> 19 to <b>1/8/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/8/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. J. BUSTO MD</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>R. J. BUSTO MD</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>200</b>		25C. FUNERAL DIRECTOR <b>Edmondson Ave., 21228</b>	

Union Memorial Hospital  
FERNIE WAITE  
X  
RETIRED  
JAMES REES  
1-18-84  
3934 ROUND HILL  
MCKINLEY  
SARAH SMITH

FUNERAL DIRECTOR: IMPORTANT

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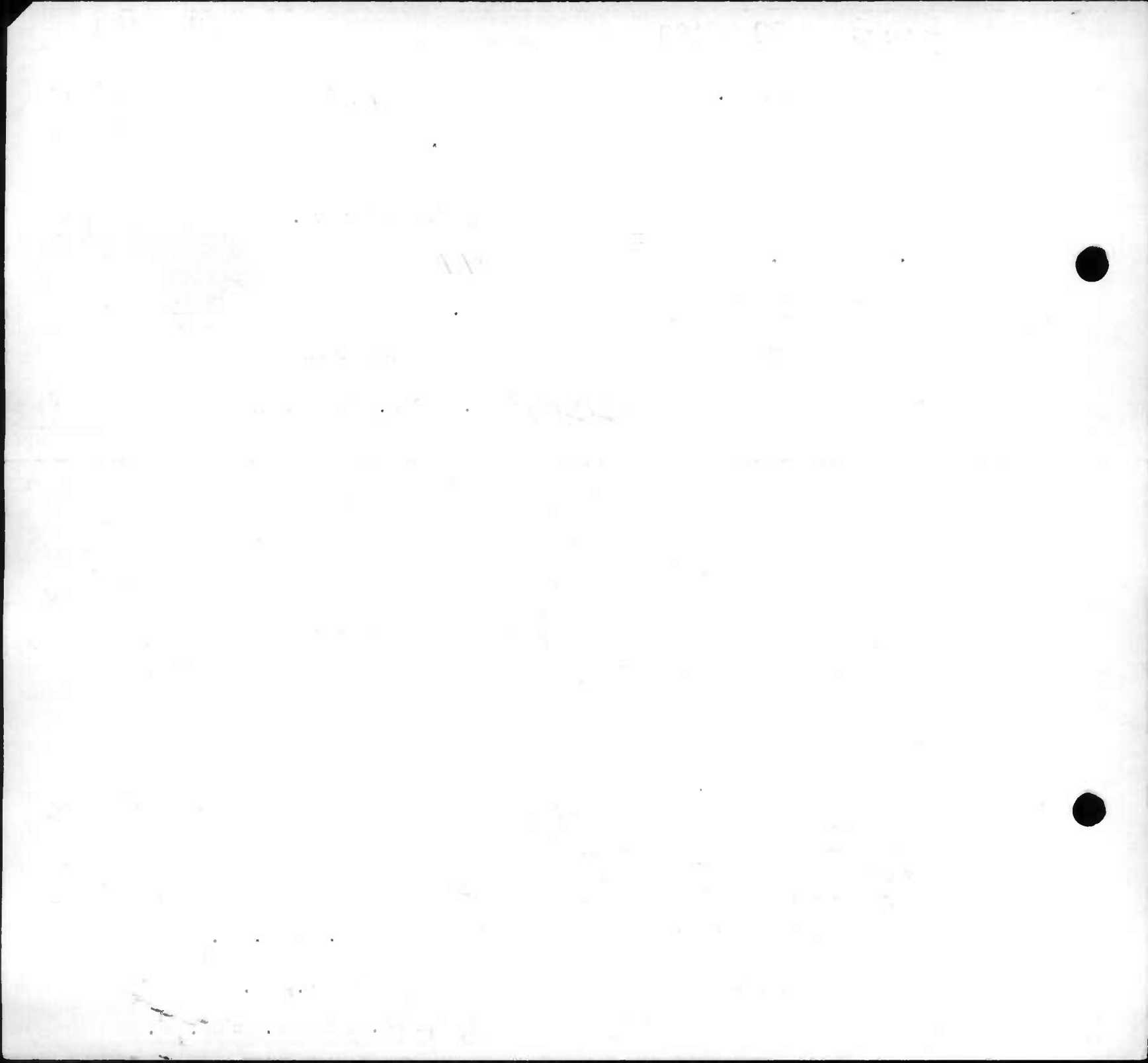
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00159</u>	
BIRTH NO. <u>W-320 72 00159</u>					
1. NAME OF DECEASED (Type or Print) <u>William G. Woods, Sr.</u>		2. DATE AND HOUR OF DEATH <u>1/5/72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>46 Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Ma</u> B. COUNTY <u>2834</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>616 Cooks Lane</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/30/1898</u>	9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John T. Woods</u>		14. MOTHER'S MAIDEN NAME <u>Emma Guard</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-9903</u>		17. INFORMANT <u>Mrs. William G. Woods, Sr., 616 Cooks Lane</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1970</u> to <u>Present</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Edgar Williamson</u>		23B. DATE SIGNED <u>1-6-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Edgar Williamson</u>	
23D. ADDRESS <u>5550 Baltimore National Pike</u>		23E. ATTENDING PHYSICIAN Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>			
25A. NAME OF REGISTRAR <u>0000</u>		25B. NAME OF REGISTRAR <u>0000</u>		25C. FUNERAL DIRECTOR <u>Witzke, 5630 Edmondson Avenue 21228</u>	



FUNERAL DIRECTOR: IMPORTANT

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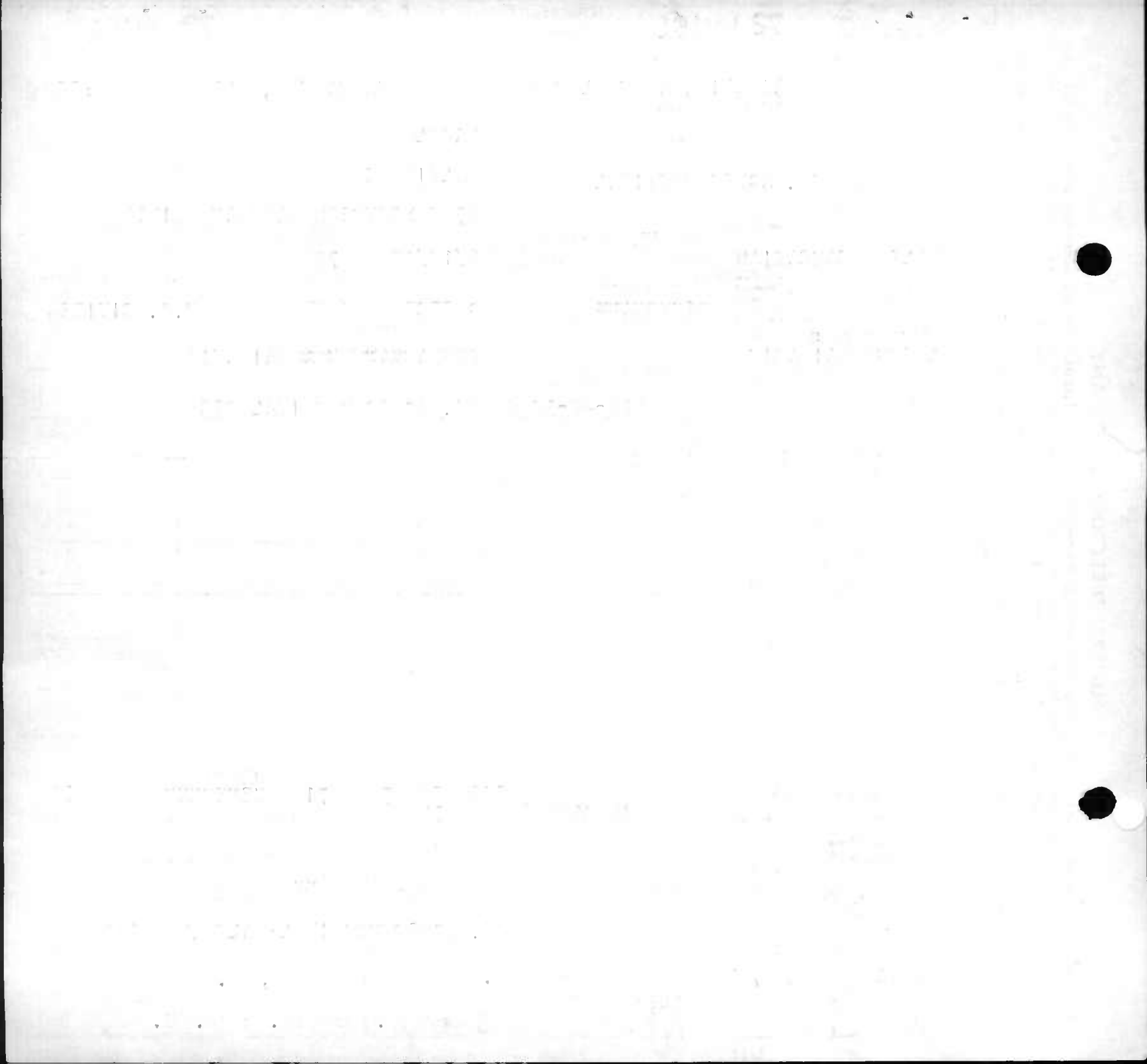
F-163		72 00160		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00160	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Marie G. Eifert</b>			
2. DATE AND HOUR OF DEATH <b>1/4/72</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>90 Long Green Nursing Home</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2744</b>				5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER <b>53 10 Holder Ave.</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. SEX <b>F.</b>		9. RACE <b>W.</b>		10. DATE OF BIRTH <b>9/5/1893</b>		11. AGE (in years last birthday) <b>78</b>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country) <b>Md.</b>		15. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. FATHER'S NAME <b>William Poplar</b>				17. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>			
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				19. SOCIAL SECURITY NO. <b>212121398</b>		20. INFORMANT <b>Mr. Carl J. Eifert same</b>	
21. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Heart failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis H.D.</b> <b>Arteriosclerosis</b> <b>Arthritis</b>				22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>10 yr</b> <b>10 yr</b>			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No)		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
31. TIME OF INJURY (Approx.)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. HOW DID INJURY OCCUR?			
34. I certify that (I) (this hospital) attended the deceased from <b>5/14</b> 19 <b>65</b> to <b>1/4</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>12/16</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
35. SIGNATURE <b>Conrad Richter MD</b>				36. DATE SIGNED <b>1/5/72</b>			
37. PHYSICIAN'S NAME (Type)				38. ADDRESS <b>3128 Harford d. Balto. Md.</b>			
39. BURIAL CREMATION, REMOVAL (Specify)		40. DATE		41. NAME OF CEMETERY or CREMATORY		42. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/7/72</b>		<b>Gardens of Faith</b>		<b>Baltimore, Md.</b>	
43. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		44. NAME OF REGISTRAR <b>Robert E. ...</b>		45. FUNERAL DIRECTOR <b>Leonard J. Buck Inc.</b>		46. ADDRESS <b>Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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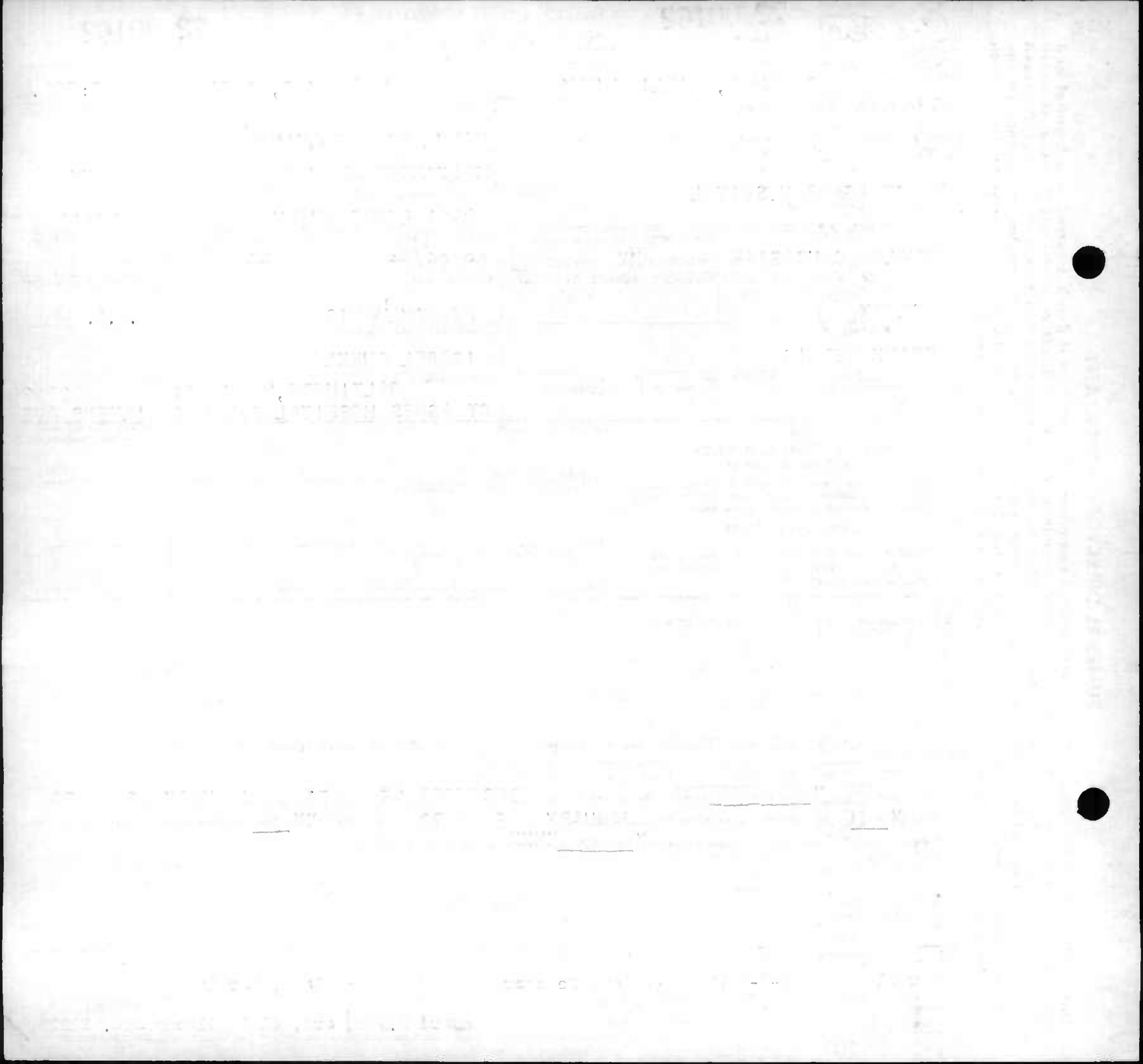
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00161</u>	
BIRTH NO. <u>D-322</u> <u>72 00161</u>					
1. NAME OF DECEASED (Type or Print) <u>DAIDAKIS, APOSTOLOS (Pa ul)</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 6, 1972</u> <u>2:55 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>40 ST. AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2747</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2705 NORTHERN PARKWAY 21214</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/15/99</u>	9. AGE (in years last birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Restaurant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>GREECE Turkey</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. CITIZEN</u>
13. FATHER'S NAME <u>Arthur Daidakis</u>		14. MOTHER'S MAIDEN NAME <u>DONNA KAVOUKISA DAIDAKIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-3529</u>		17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS</u>	
18. <u>16211</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma Lung i</u> <u>Metastases</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 27</u> 19 <u>71</u> to <u>DECEMBER 6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>JANUARY 6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Romualdo R. Dator</u>				23B. DATE SIGNED <u>1-6-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Romualdo R. Dator, M.D.</u>				23D. ADDRESS <u>ST. AGNES HOSPITAL; BALTO, MD 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/10/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		24F. NAME OF REGISTRAR <u>Robert E. Falber, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Leonard J. Puck Inc.</u>		24H. ADDRESS <u>Balto. Md.</u>			





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C-656		BALTIMORE CITY HEALTH DEPARTMENT		72 00162	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. 72 00162	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CREAMER, LILLIAN MAY		JANUARY 3, 1972		5:50A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		BALTIMORE	
40 ST AGNES HOSPITAL		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE ARBUTUS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		4921 LEEDS AVENUE		21227	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
FEMALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	09/06/83	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CLERK				PENNSYLVANIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FRANK WERNIG		ISABEL RUNKLE		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				BALTIMORE, MARYLAND 21229	
				ST AGNES HOSPITAL CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		C.V.A.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Atrial fibrillation.			
		(C) Arterio-sclerotic heart dis.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 25 1971 to JANUARY 3 1972					
that (X) (we) last saw the deceased alive on JANUARY 3 1972 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
N. Stratigakos		1.3.72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NICH. STRATIGAKOS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-6-1972		Woodlawn Cemetery	
				Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 10 1972		Robert J. Fisher, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



W-450

72 00163

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00163

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES M. WHELAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1930 Parksley Ave.</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 3 1972 9:18 a</b> M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10-18-1907</b>		10. AGE (In years last birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>McCormick Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>		17. SOCIAL SECURITY NO. <b>215-05-6869</b>	
15. MOTHER'S MAIDEN NAME <b>Anna Bamberger</b>		18. INFORMANT <b>Mrs. Margaret T. Hupfeld, 2710 Chesley Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-3-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-6-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Carrolls Chapel Meth. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Russell S. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		ADDRESS <b>21229</b>	

75 10001

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75 10001



*Handwritten signature*

1-1-1971

1-1-1971

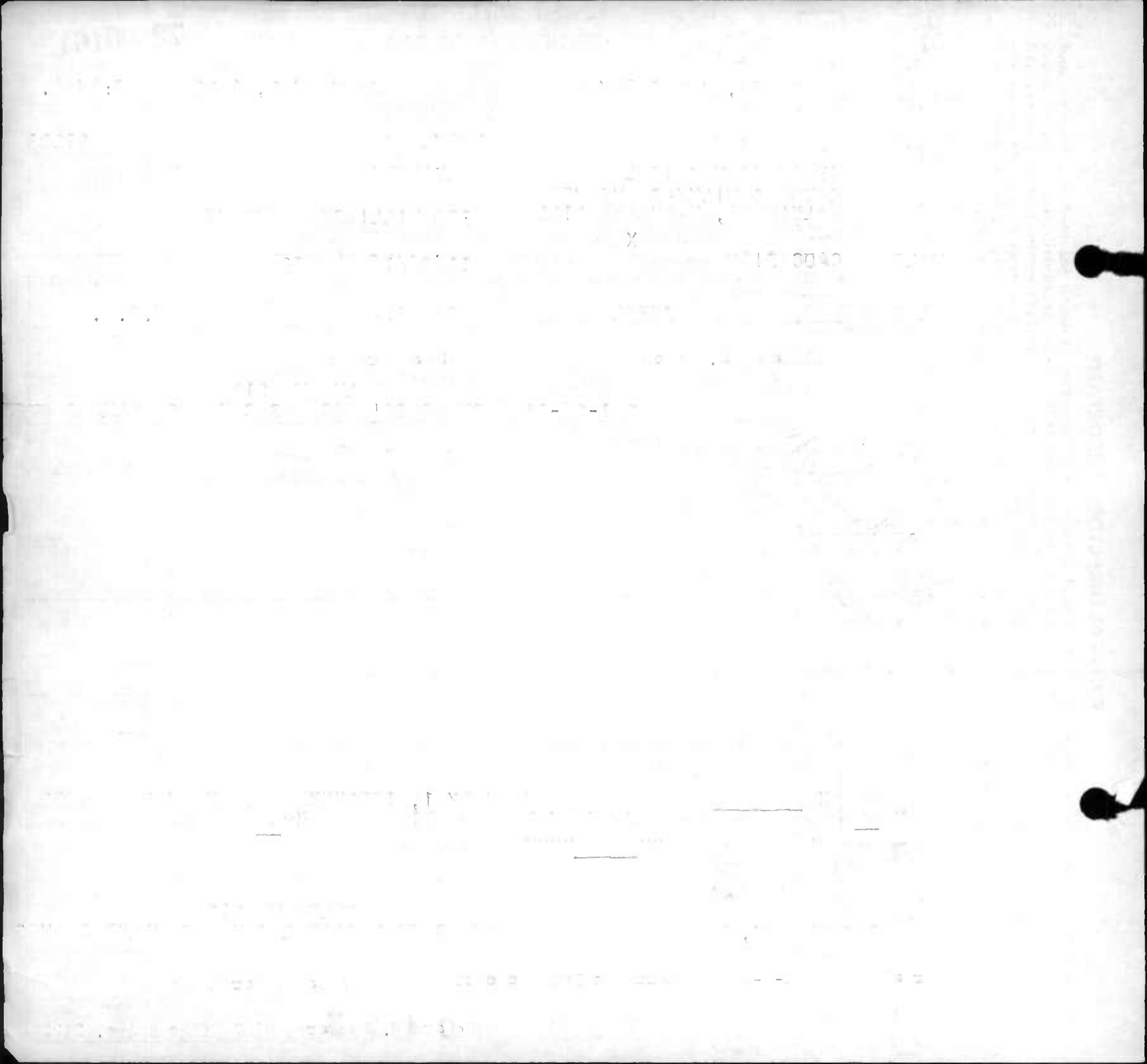
1-1-1971

1-1-1971

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

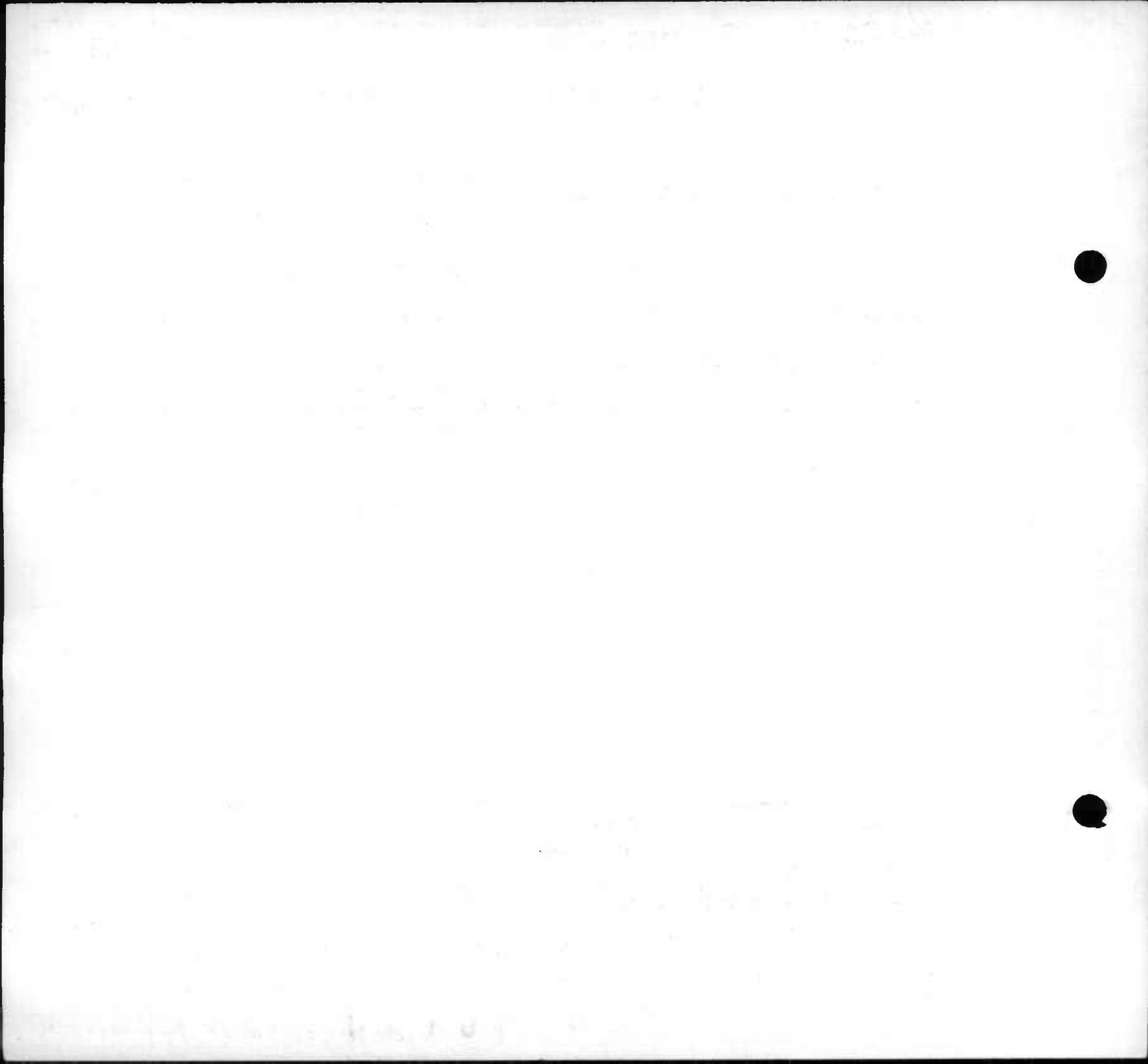
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00161	
B-500 72 00161					
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>BOWEN, JAMES PRYOR</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 2, 1972 5:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2005 21223</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>11/06/18</b> 9. AGE (In years last birthday) <b>53</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William A. Bowen</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Crooks</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>261-26-1388</b>			17. INFORMANT <b>BALTO MD 21229</b> ADDRESS <b>ST AGNES' RECORDS CATON &amp; WILKENS AVES</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. (means the disease, injury or complication which caused death.) <b>Brain Contusions</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Multiple Skull Fr's</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>30 hrs.</b>		
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1/1/72</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>coma</b>		
20A. AUTOPSY? (Yes or No) <b>no</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>yes</b>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>stairs in home 20-05</b>			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>12/31/71 11 p.m.</b>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? <b>fell down stairs</b>		
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 1, 1972</b> to <b>JANUARY 2, 1972</b> that (X) (we) last saw the deceased alive on <b>JANUARY 2, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C.R. Chaney</b>			23B. DATE SIGNED <b>1/2/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>C R CHANEY, MD</b>			23D. ADDRESS <b>BALTO MD 21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>		24E. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		24F. ADDRESS <b>4107 Wilkens Ave. 21229</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00165</u>	
P-600 72 00165 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LOUISA (LULA) K. PARR</u>		2. DATE AND HOUR OF DEATH <u>JAN. 6, 1972</u> <u>6:45A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 ARDLEIGH NURSING HOME</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>701</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>522 N. STREEPER ST.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1892</u>	9. AGE (in years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>GEORGE WEGGEL</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-09-7574D</u>		17. INFORMANT <u>Mr. George C. Parr, Jr. - 4207 Diller Ave.</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR D'S.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>DEC 15, 1968</u> to <u>JAN. 6, 1972</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>JAN. 5, 1972</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Lloyd E. Saylor M.D.</u>			23B. DATE SIGNED <u>1-6-72</u>		23C. PHYSICIAN'S NAME (Type) <u>LLOYD E. SAYLOR, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>1-10-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>James H. Miller - 2334 Jefferson St.</u>

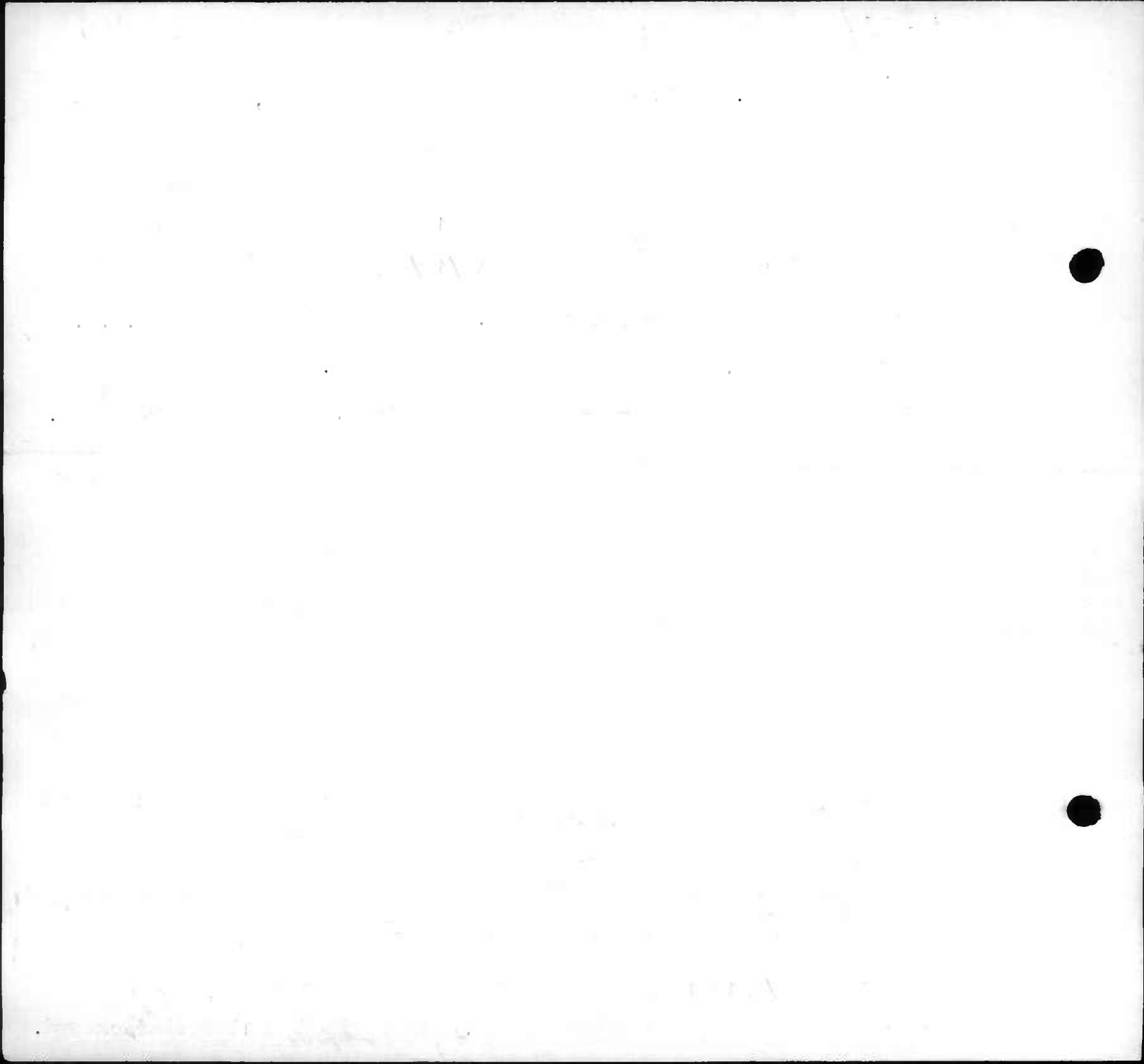




FUNERAL DIRECTOR: IMPORTANT

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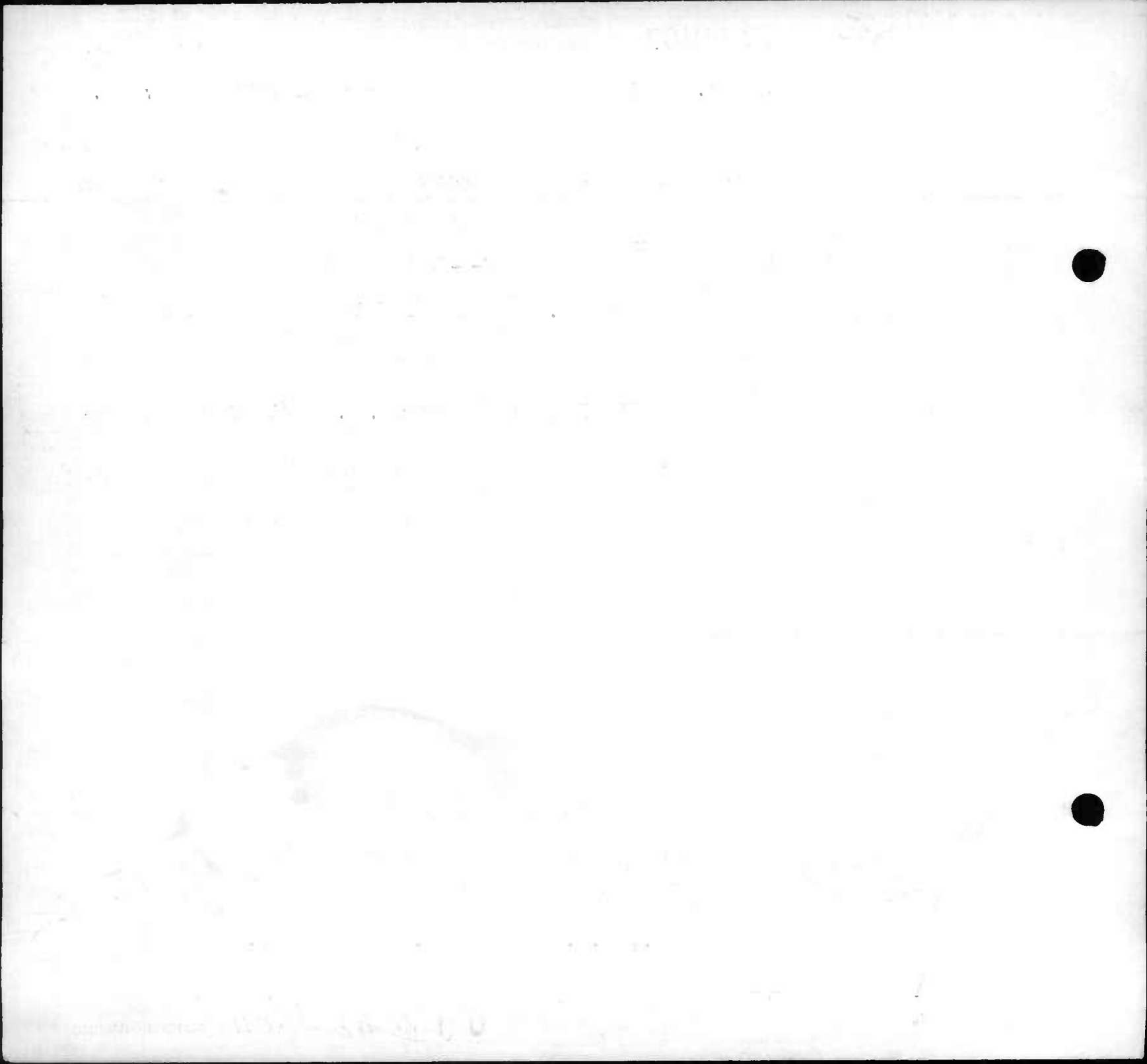
<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print)</p> <p style="text-align: center;">Roy G. Lindler</p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="text-align: center;">January 2, 1972</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">4514 Manorview Road</p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>2864</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>4514 Manorview Road</u></p>	
<p><b>5. SEX</b></p> <p>Male <input checked="" type="checkbox"/> Female <input type="checkbox"/></p>	<p><b>6. RACE</b></p> <p>White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b></p> <p><u>10/17/1904</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><u>Printer</u></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><u>South Carolina</u></p>	
<p><b>13. FATHER'S NAME</b></p> <p><u>Hezekiah N. Lindler</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><u>U.S.A.</u></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>No <input checked="" type="checkbox"/></p>		<p><b>16. SOCIAL SECURITY NO.</b></p> <p><u>242-05-4696</u></p>	
<p><b>17. INFORMANT</b></p> <p><u>Mrs Bessie A. Lindler</u></p>		<p><b>ADDRESS</b></p> <p><u>4514 Manorview Rd.</u></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>Ca of Lung</u></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><u>3 mo</u></p>	
<p><b>19A. DATE OF OPERATION</b></p> <p><u>1/6/1971</u></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p> <p><u>Ca of Lung</u></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p> <p><input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p><u>Ca of Lung</u></p>	
<p><b>21D. TIME OF INJURY (APPROX.)</b></p> <p>(Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b></p> <p><u>Dec 30 1971</u> <b>that (I) (we) last saw the deceased alive on</b></p> <p><u>Jan 2 1972</u> <b>and that (my) (our) opinion death occurred on the date</b></p> <p><u>Jan 2 1972</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/></p> <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>23A. SIGNATURE</b></p> <p><u>J. C. POUND</u></p>		<p><b>23B. DATE SIGNED</b></p> <p><u>1/4/72</u></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><u>J. C. POUND</u></p>		<p><b>23D. ADDRESS</b></p> <p><u>3325 Frederick Ave</u></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p><u>Burial</u></p>		<p><b>24B. DATE</b></p> <p><u>1/6/1971</u></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b></p> <p><u>New Cathedral Cemetery</u></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><u>Baltimore, Maryland</u></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT</b></p> <p><u>JAN 10 1972</u></p>		<p><b>25B. NAME OF REGISTRAR</b></p> <p><u>John E. Schwab</u></p>	
<p><b>25C. FUNERAL DIRECTOR</b></p> <p><u>John E. Schwab</u></p>		<p><b>ADDRESS</b></p> <p><u>3512 Frederick Ave.</u></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

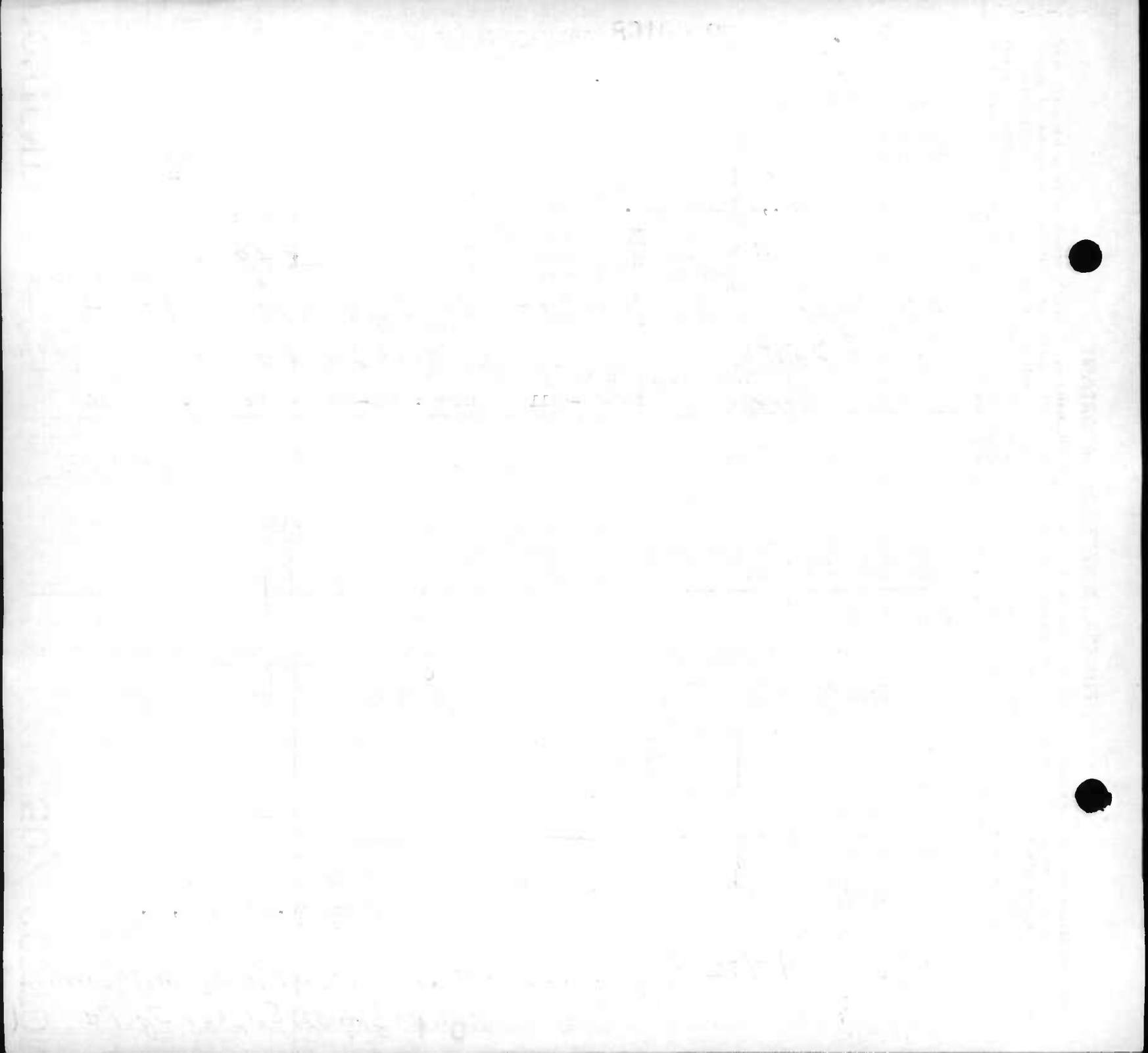
<div style="display: flex; justify-content: space-between;"> <span>M-450</span> <span>72 00167</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">72 00167</span>								
BIRTH NO. <span style="font-size: 1.5em;">1</span>										
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Robert L. Mullin</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">January 4, 1972</span> <span style="font-size: 1.2em;">5:45 p.</span>								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">31</span> <span style="font-size: 1.2em;">Baltimore City Hospital</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">BALTO</span> <span style="font-size: 1.5em;">5300</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">21 Mulberry Lane</span>								
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Caucasian</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH <span style="font-size: 1.2em;">1-8-1905</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">66</span>								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Paul Jones Dist.</span>								
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">West Virginia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>								
13. FATHER'S NAME <span style="font-size: 1.2em;">unknown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unknown</span>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214 07 0976A</span>								
17. INFORMANT <span style="font-size: 1.2em;">Christina M. B. Mullin</span>		ADDRESS <span style="font-size: 1.2em;">21 Mulberry Lane</span>								
18. CAUSE OF DEATH <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">                     DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                      ANTECEDENT CAUSES                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </td> <td style="width: 40%;">                     APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 </td> </tr> <tr> <td>                     (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Generalized Carcinomatosis.</span>  <span style="font-size: 1.5em;">Carcinoma - Rt. Lung</span> </td> <td></td> </tr> <tr> <td>(B) DUE TO, OR AS A CONSEQUENCE OF:</td> <td></td> </tr> <tr> <td>(C)</td> <td></td> </tr> </table>			DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Generalized Carcinomatosis.</span> <span style="font-size: 1.5em;">Carcinoma - Rt. Lung</span>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Generalized Carcinomatosis.</span> <span style="font-size: 1.5em;">Carcinoma - Rt. Lung</span>										
(B) DUE TO, OR AS A CONSEQUENCE OF:										
(C)										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <span style="font-size: 1.2em;">8/2/70</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Ca - Rt. Lung</span>	20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>								
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/19/62</span> 19____ to <span style="font-size: 1.2em;">11/8/71</span> 19____ that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11/8/71</span> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. <span style="font-size: 1.2em;">City Hosp.</span>										
23A. SIGNATURE <span style="font-size: 1.5em;">L. Vogel Jr.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/5/72</span>								
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Louis Vogel, Jr., M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">2601 E. Monument St. - 21205</span>								
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">1-7-72</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Baltimore Cemetery</span>								
		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>								
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 10 1972</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert L. Mullin</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">1211 Chesaco Avenue</span>								



# FUNERAL DIRECTOR: IMPORTANT

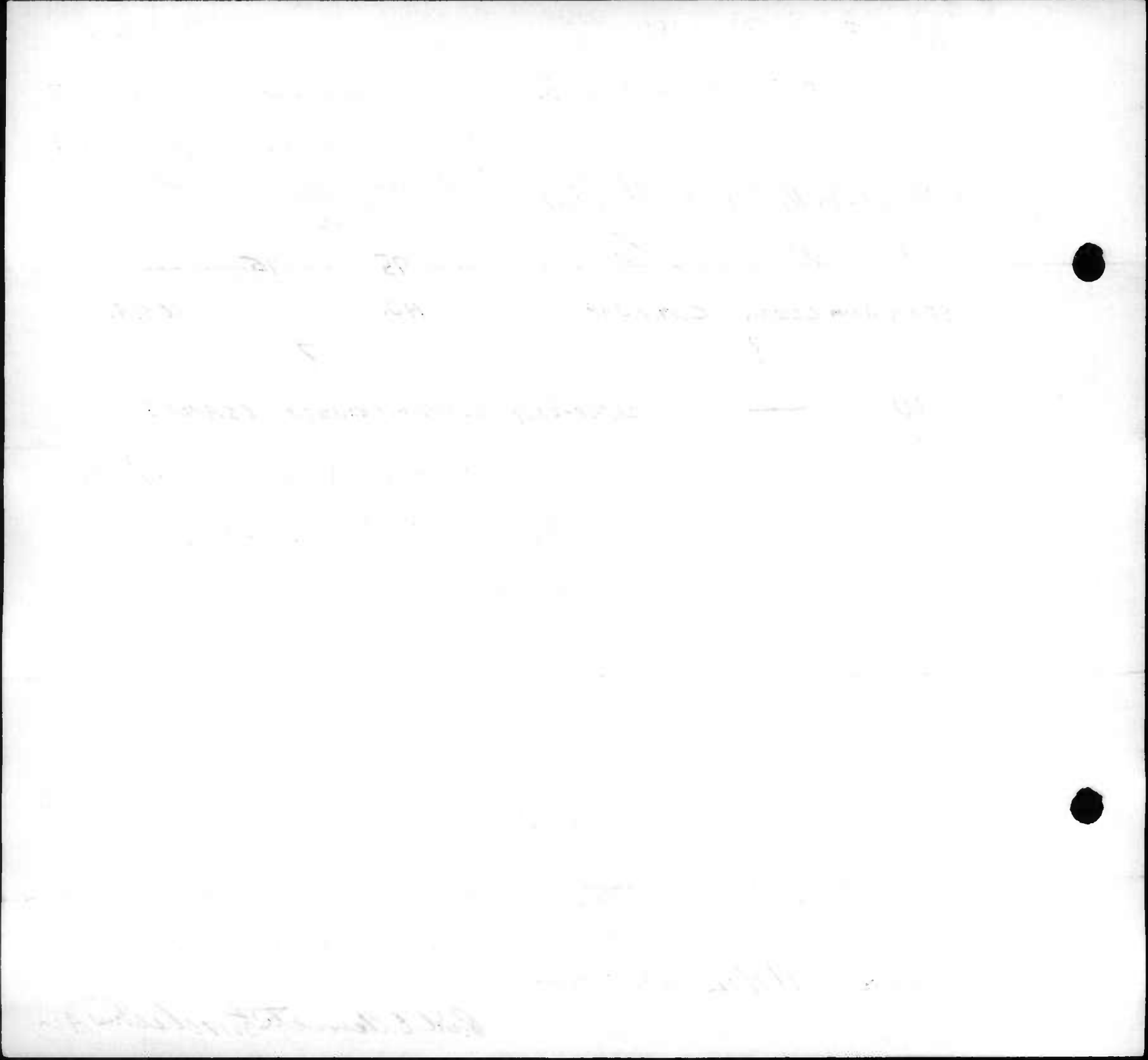
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00168	
BIRTH NO. 5-530		72 00168		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <b>BOYD JOSEPH SMITH</b>		2. DATE AND HOUR OF DEATH <b>1/3/72 6:20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Ave., Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>202</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>242 South Durham Street 21231</b>			
5. SEX <b>Male</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/31/28</b>	9. AGE (in years last birthday) <b>43</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Layer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John E Smith</b>		14. MOTHER'S MAIDEN NAME <b>Charlie Lee Wallace</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Korean</b>		16. SOCIAL SECURITY NO. <b>298-26-8311</b>		17. INFORMANT <b>Records: BCH-4940 Eastern Ave. 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>HEPATO RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>12 HOURS</b>	
(C) <b>CIRRHOSIS</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>G.I. bleed, hypotension</b>		<b>8 HOURS</b>	
19A. DATE OF OPERATION <b>1/3/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1/2/72</b> 19 to <b>1/3/72</b> 19 that (I) <del>(we)</del> last saw the deceased alive on <b>1/3/72</b> 19 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>John J. Chabaliko, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/3/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN J. CHABALIKO</b>		23D. ADDRESS <b>4940 Eastern Ave. Baltimore, Md. 21224</b> <b>BALTIMORE CITY HOSPITALS</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/7/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Watauga County, North Carolina</b>		24E. STATE <b>North Carolina</b>			
25A. DATE RECD BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Salyer, M.D.</b>		25C. FUNERAL DIRECTOR <b>Ambrase J. 1325 Sulphur Sq. Rd.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-263		72 00169		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00169	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>REXROTH, LOUIS S.</b>				2. DATE AND HOUR OF DEATH <b>January 4, 1972 1:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MONTEBELLO STATE HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Above 1207</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/95</b>	9. AGE (in years last birthday) <b>75</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK ROOM CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C.M. HEMP</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-18-2359</b>		17. INFORMANT <b>ROLAND C. REXROTH (SAME)</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Heart failure</b> <b>Arteriosclerotic cardiovascular disease</b> <b>Cerebral vascular accident. Hemiplegia</b> <b>Diabetes mellitus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>none</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>none</b>		21F. HOW DID INJURY OCCUR? <b>none</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5-21-69</b> 19 to <b>January 4, 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ming Kuei Liu M.D.</b>				23B. DATE SIGNED <b>January 4, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>MING KUEI LIU M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/7/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>FAKE VIEW</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Paul B. Bennett</b>		25C. FUNERAL DIRECTOR <b>3617 Chestnut Ave.</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00170	
<b>M-452</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>HELEN K. MULLINEAUX</b>		<b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <b>01-05-72 4:30 P.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> Church Home & Hospital 100 N. Broadway St. Baltimore, MD 21231		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore County</b> <b>5. CITY OR TOWN</b> <b>County</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3399 Liberty Garden Rd 21207</b>			
<b>5. SEX</b> <b>Female</b> <b>6. RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>02-03-94</b> <b>9. AGE</b> (in years last birthday) <b>77</b> <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MD</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Henry KLOHR</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Kalb</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (if yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-10-4492B</b>		<b>17. INFORMANT</b> <b>Mrs. Mary Wynne, 3399 Liberty Garden Road, Baltimore, Md. 21207</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>486X1</b> <b>Pneumonia</b>		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Unknown</b>			
<b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>		<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) _____</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<b>ASC-V-D-C-H-F</b>			
<b>19A. DATE OF OPERATION</b> <b>2 None</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>None</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>Yes</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>None</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>None</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>None</b>		<b>21E. INJURY OCCURRED</b> <b>None</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <b>None</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 12-17-1971 to 1-5-1972 that (I) (we) last saw the deceased alive on 1-5-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Satpal Singh M.D.</b>		<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>1-5-72</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>SATPAL SINGH M.D.</b>		<b>23D. ADDRESS</b> <b>Church Home &amp; Hospital, Baltimore, Md.</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>1/8/72</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Mt. Olive Church Cemetery</b>	
<b>24D. LOCATION</b> <b>Randallstown, Baltimore, Maryland</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 10 1972</b>			
<b>25B. NAME OF REGISTRAR</b> <b>John E. Kelly, Jr.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Foring Evers Funeral Directors P.A.</b> <b>5728 Liberty Road, Randallstown, Md. 21133</b>			

05-11-57

23

JS-11-4

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

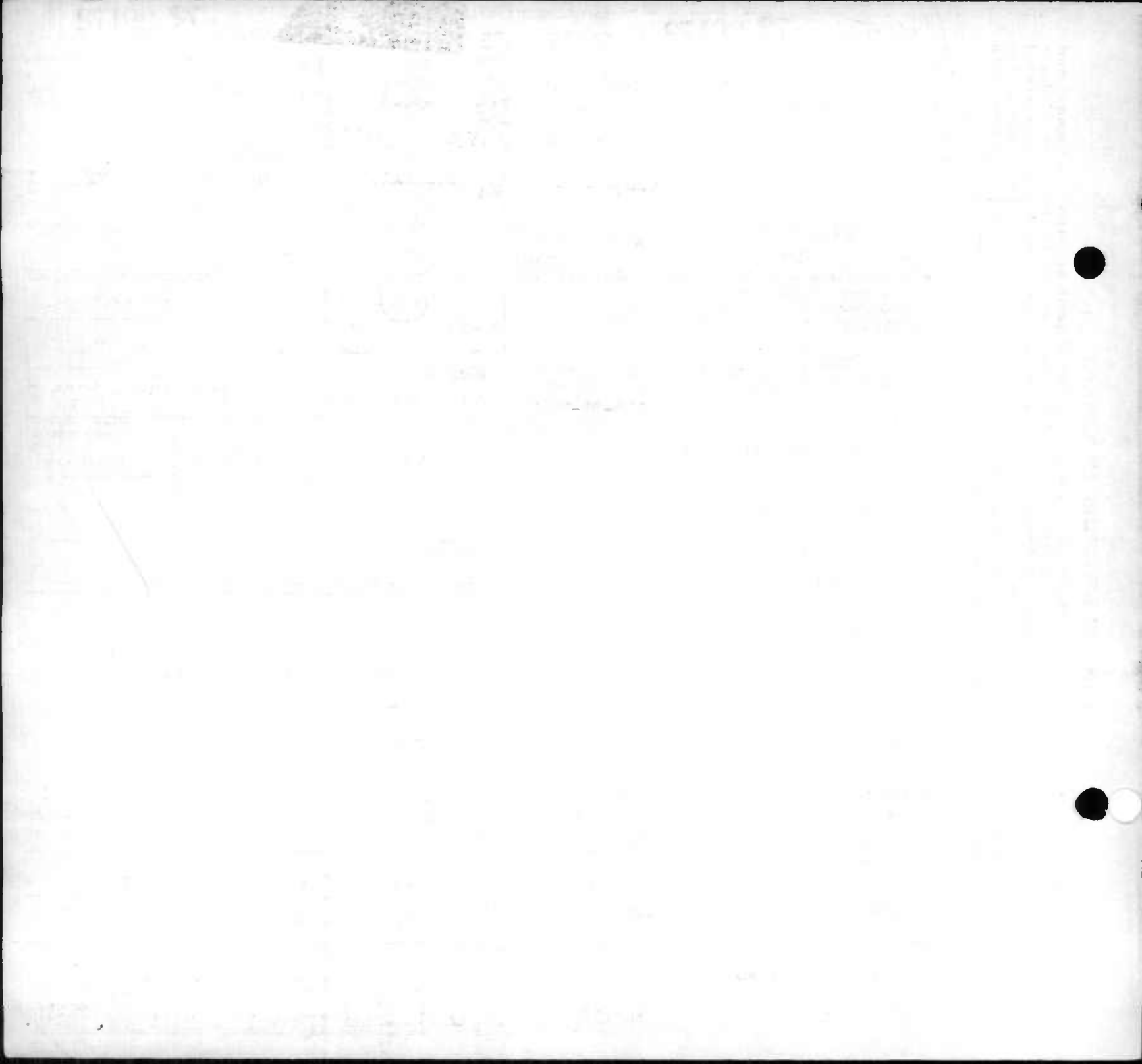
BIRTH NO. <u>M-610</u>				46-59-92				72 00171				72 00171			
46-59-92								72 00171							
46-59-92								72 00171							
1. NAME OF DECEASED (Type or Print) <u>HILDA Frances Murphy</u>								2. DATE AND HOUR OF DEATH <u>1/2/72</u> <u>11:20 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE CITY</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u>				IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
4940 Eastern Avenue, Baltimore, Maryland 21224								E. STREET AND NUMBER <u>246 320 Boston St</u> <u>2636</u>							
5. SEX <u>Female</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/23/10</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>				11. BIRTHPLACE (State or foreign country) <u>HAVRE DE GRACE, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WASHINGTON CLAYTON MURPHY</u>								14. MOTHER'S MAIDEN NAME <u>GRACE M. MEYERS</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u> <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNK.</u>				17. INFORMANT BCH RECORDS: <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				ADDRESS			
18. <u>486X17830.9</u> CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)								(A) IMMEDIATE CAUSE <u>Septicemic Shock</u> <u>1 wk</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								(B) <u>Pneumonia - Pulm. Failure</u> <u>3 wks</u>							
								(C) <u>Liver failure</u> <u>1 wk</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus, Hypothyroidism</u>															
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1/15</u> 19 <u>71</u> to <u>1/2/72</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1/2</u> 19 <u>72</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.															
23A. SIGNATURE <u>P. Kurzweil, MD</u>								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>1/2/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Peter Kurzweil, MD</u>								23D. ADDRESS <u>Baltimore City Hospitals</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>1/7/1972</u>				24C. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEMETERY</u>				24D. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, HARFORD, MD.</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 10 1972</u>								25B. NAME OF REGISTRAR <u>Robert S. Gabe</u>				25C. FUNERAL DIRECTOR <u>Bernard J. Lee, Havre de Grace, Md.</u>			

1510-27

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

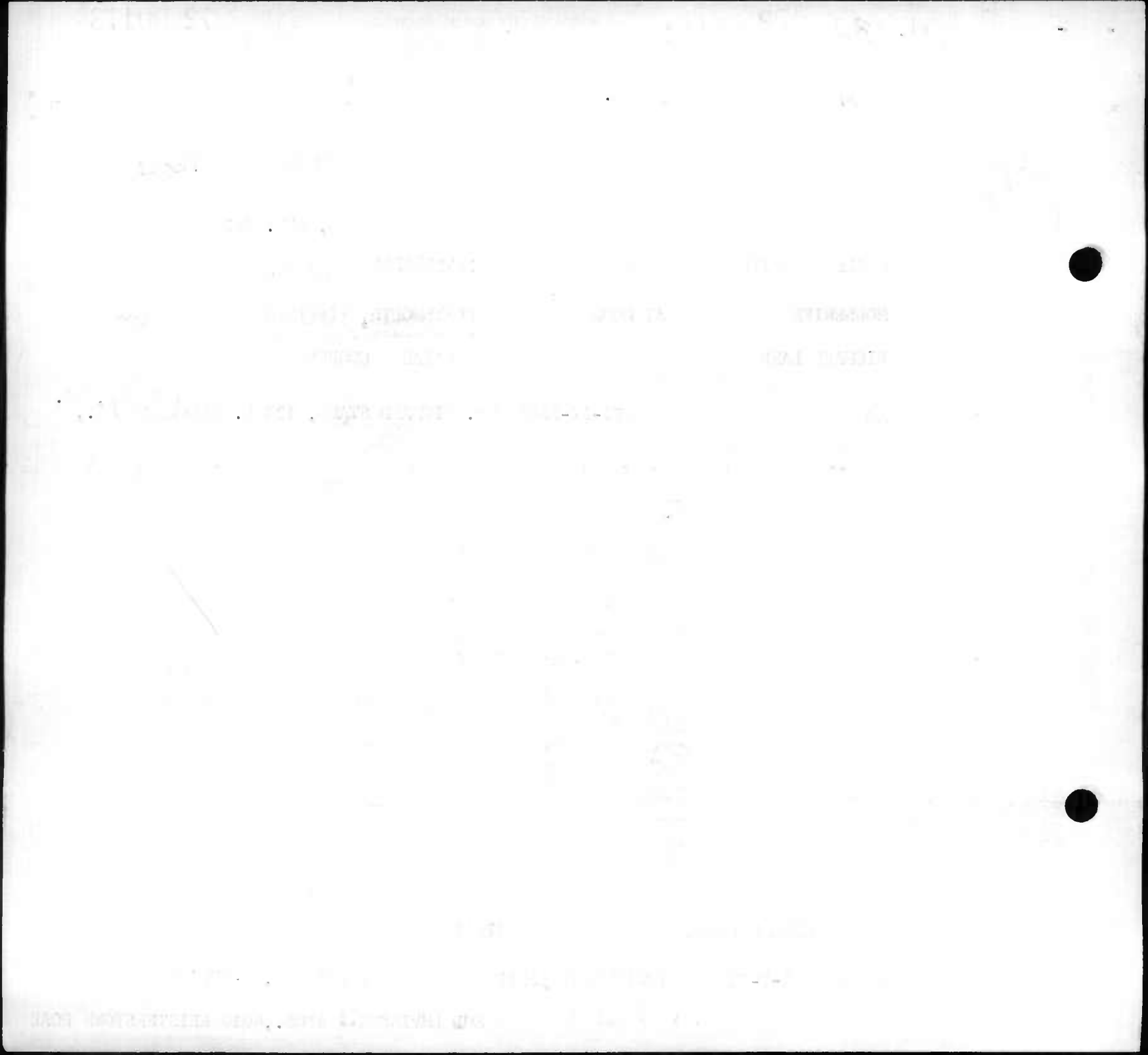
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">X</span>	
<div style="font-size: 2em; font-weight: bold;">P-465</div> <div style="font-size: 1.5em;">72 00172</div>		<div style="font-size: 1.5em;">72 00172</div>			
<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
PALERMO, EMILY M.		1/6/72 1 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD.		B. COUNTY Baltimore	
Union Memorial Hospital		C. CITY OR TOWN Rossville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
44		E. STREET AND NUMBER 8412 Allison Lane			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/11	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Vernon Keng		14. MOTHER'S MAIDEN NAME C. Lara Stoops	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 211-03-2462		17. INFORMANT Mr. Louis Palermo	
				ADDRESS 8412 Allison Lane Bal. MD 21237	
18. <span style="font-size: 1.5em;">4359</span>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">An aneurysm of vertebral</span>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1/12/1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Basilar artery insufficiency due to vertebral aneurysm		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-08-71</u> 19 <u>71</u> to <u>1/6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">G. KHANI</span> MD DEGREE				23B. DATE SIGNED 1/6/72	
23C. PHYSICIAN'S NAME (Type) GHASSAN KHANI				23D. ADDRESS U. M. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/8/72		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	
24D. LOCATION Baltimore		24E. LOCATION Baltimore		24F. LOCATION Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR R. E. Kelly		25C. FUNERAL DIRECTOR Lorraine Funeral Home	
				ADDRESS 7401 Belair Rd. Balt. 21236	



# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>M-232 72 00173</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>72 00173</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	
BIRTH NO. <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>		1. NAME OF DECEASED (Type or Print) <u>Moskowitz, Frances L.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore Inc.</u>		2. DATE AND HOUR OF DEATH <u>1-6-72</u> <u>5:10</u> <u>A.M.</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>11 Slade Ave.</u>		APT. <u>402</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXX</u>
9. AGE (in years last birthday) <u>69</u>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PORTSMOUTH, VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD LAND</u>		14. MOTHER'S MAIDEN NAME <u>SARAH COOPER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>072-12-3588</u>	
17. INFORMANT <u>MR. RICHARD STAUB</u>		ADDRESS <u>SUFFOLK, VA.</u>	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>10 yrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ovarian carcinoma</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>11 yrs.</u>	
(C) _____		(C) _____	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12-30 1971</u> to <u>1-6 1972</u> that (1) (we) last saw the deceased alive on <u>1-6 1972</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jack Pollack</u>		23B. DATE SIGNED <u>Jan. 6, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>JACK POLLACK</u>		23D. ADDRESS <u>SINAI</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-7-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>SCD LEVINSON</u>	
25C. FUNERAL DIRECTOR <u>BROS.</u>		ADDRESS <u>6010 REISTERSTOWN ROAD</u>	

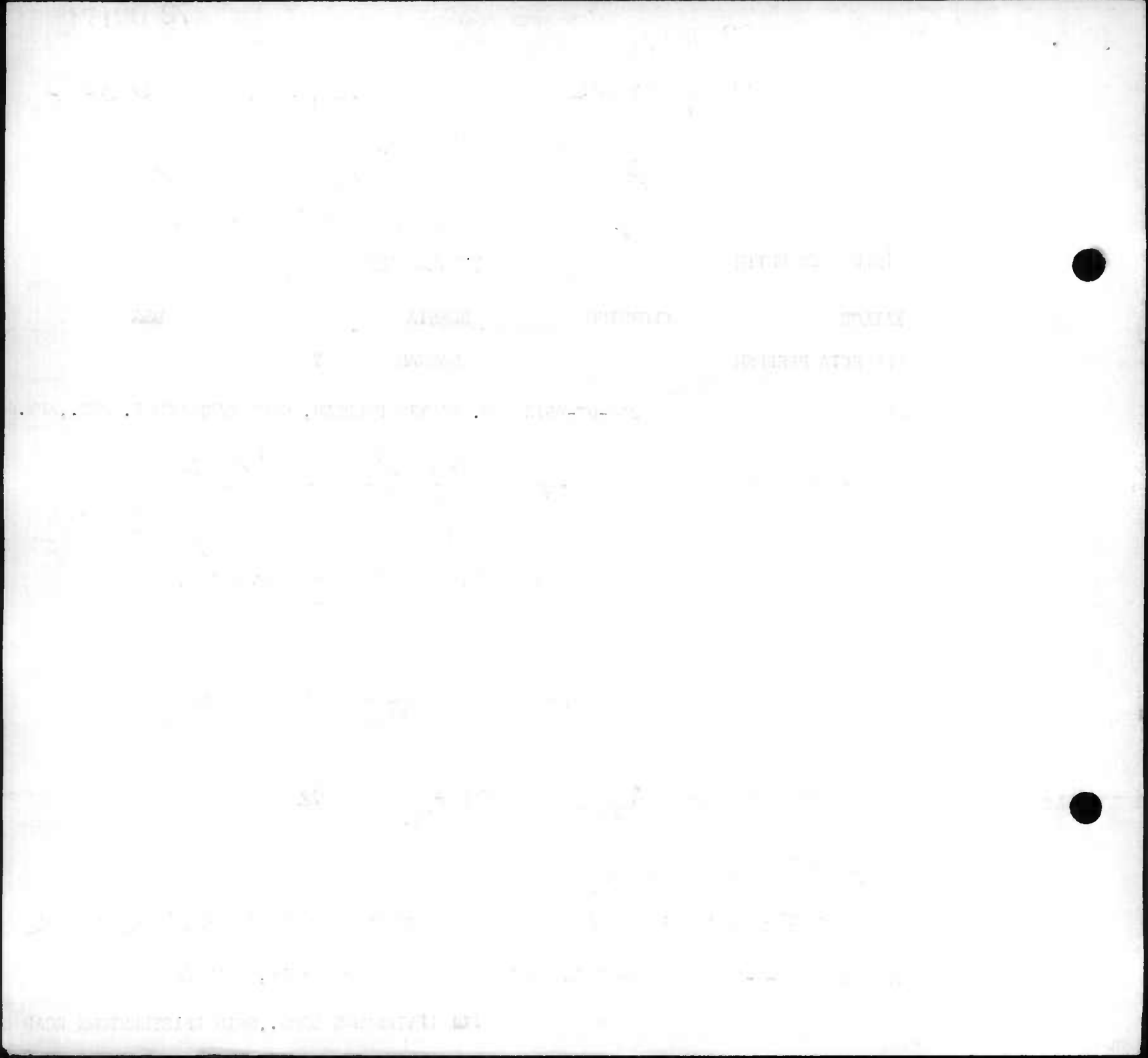




# FUNERAL DIRECTOR: IMPORTANT

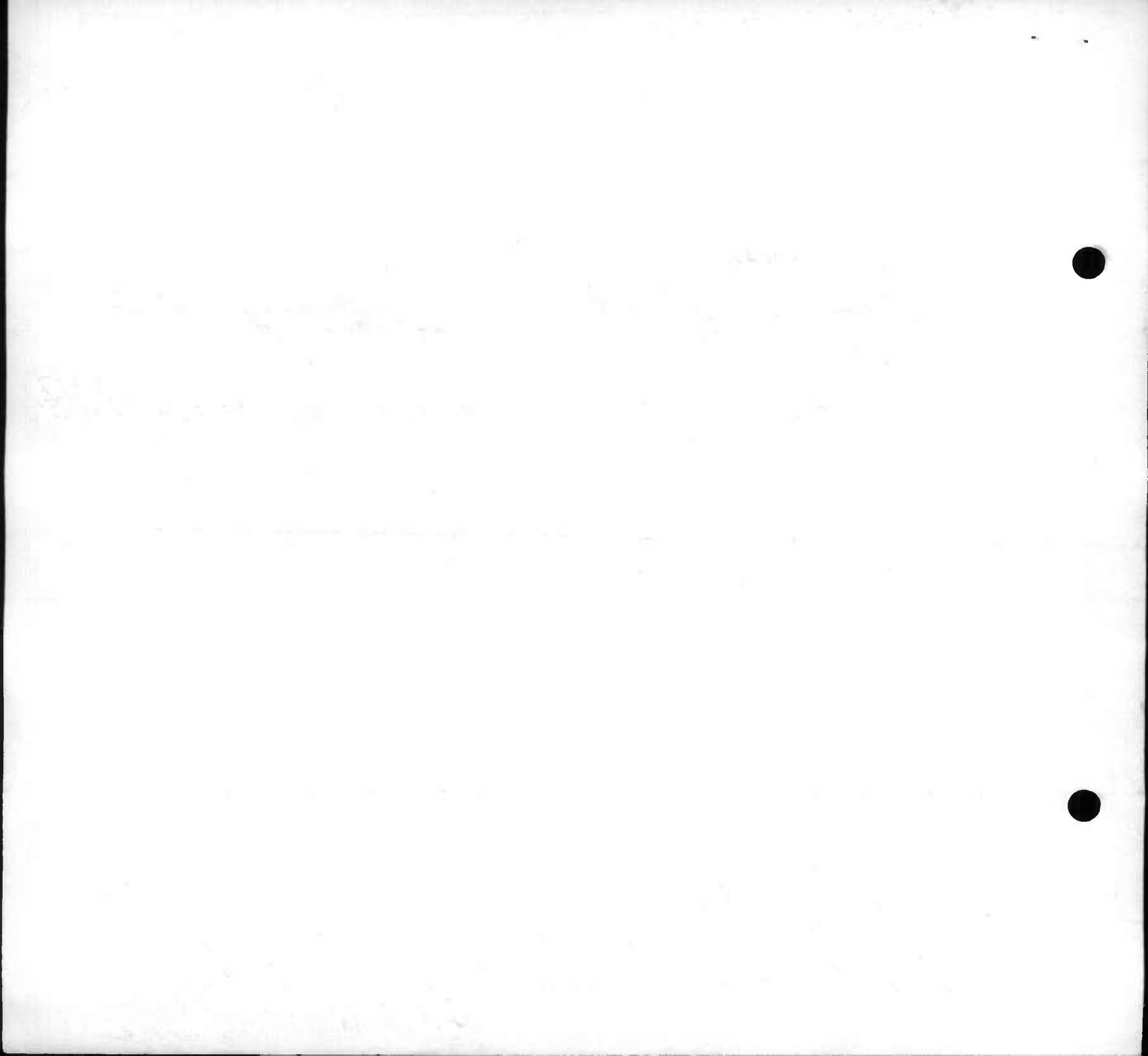
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 00174 CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>P-612</u>		1. NAME OF DECEASED (Type or Print) <u>PREBESH, SAMUEL</u>			
2. DATE AND HOUR OF DEATH <u>1-6-72 9:05 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>XXXXXX18X</u>		9. AGE (In years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MORDECIA PREBESH</u>	
14. MOTHER'S MAIDEN NAME <u>HANNAH ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-0515</u>	
17. INFORMANT <u>MR. MARTIN PREBESH, 6807 PARK HGHTS. AVE., APT. 4</u>		ADDRESS			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CVA</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Vascular Disease</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 4</u> 19 <u>72</u> to <u>Jan. 6</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>Jan. 6</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Thananopavar N.M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>C. THANANOPAVARN, M.D.</u>	
23D. ADDRESS <u>SINAI HOSP. OF BALTIMORE INC</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-7-72</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		24E. FUNERAL DIRECTOR <u>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			
25A. DATE RECD BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>REBECCA</u>		25C. ADDRESS	



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<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <u>LOUIS F. LANDAU</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p><u>1/3/72</u> <u>7:15 A.M.</u></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>MARYLAND GENERAL HOSPITAL</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>MD</u> B. COUNTY <u>1102</u></p> <p>C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>515 PARK AVENUE</u></p>	
<p><b>5. SEX</b> <u>Male</u></p>	<p><b>6. RACE</b> <u>White</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>11-21-93</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Retail</u></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>EUROPE-Germany</u></p>
<p><b>13. FATHER'S NAME</b> <u>Unknown Landau</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI-Army</u></p>		<p><b>16. SOCIAL SECURITY NO.</b> <u>217-07-4007</u></p>	<p><b>17. INFORMANT</b> <u>Mr. Faye Cohen</u> ADDRESS <u>21207 St. Fulbright</u></p>
<p><b>18. CAUSE OF DEATH</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Kaposi's Sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u></p> <p>(B) <u>ASCVD &amp; Mitral insuff &amp; CHF</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>anemia 2° # A</u></p>			
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 12</u> 19 <u>71</u> <b>to</b> <u>Jan 3</u> 19 <u>72</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 3</u> 19 <u>72</u> <b>and that (my) (our) opinion death occurred on the date</b> <u>Jan 3</u> 19 <u>72</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <u>Beltran</u> M.D.</p>		<p><b>23B. DATE SIGNED</b> <u>1/3/72</u></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <u>JUAN A. BELTRAN M.D.</u></p>		<p><b>23D. ADDRESS</b> <u>MARYLAND GENERAL HOSPITAL</u></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>	<p><b>24B. DATE</b> <u>1/6/72</u></p>	<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Chesapeake</u></p>	<p><b>24D. LOCATION</b> (City, town, or county) <u>Balto, Md.</u></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 10 1972</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>John J. Lewis</u></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <u>John J. Lewis</u></p>		<p><b>25D. ADDRESS</b> <u>6010 Reister Rd.</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00177		REG. NO. 72 00177	
BIRTH NO. <u>K-410</u>				<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Klaro, Meta</u>				2. DATE AND HOUR OF DEATH <u>1-5-72</u> <u>4:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore Inc.</u> <u>42</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2831</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>6616 VINCENT LANE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-04</u>	9. AGE (In years last birthday) <u>67</u>	11. Under 1 Yr. Months: Days: Hours: Min.	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN MELAWER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-30-7386</u>		17. INFORMANT <u>MR. PETER F. RUSSEL, 2700 SUMMERSON RD. #21209</u>			
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>T.B. Thoracoplasty, chronic bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<u>Inappropriate F.D.H. syndrome</u>		<u>2 days</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-2-1972</u> to <u>1-5-1972</u> that (I) (we) last saw the deceased alive on <u>1-5-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jack Pollack</u>				23B. DATE SIGNED <u>1-5-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>JACK POLLACK</u>				23D. ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-6-72</u>		24C. NAME of CEMETERY or CREMATORY <u>CHEVRA AHAVAS CHESD</u>		24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS.</u>		ADDRESS <u>6010 REISTERSTOWN ROAD</u>	

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 00178

**K-620** 72 00178

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **KARIS, DORIS M.** 2. DATE AND HOUR OF DEATH **1-6-72 1 405 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Baltimore City Hospitals 21223 4940 Eastern Avenue, Baltimore, Maryland**

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE **MD** B. COUNTY

C. CITY OR TOWN **Baltimore** D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER **1844 McHenry St. 21222**

5. SEX **Female** 6. RACE **Caucasian** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **3-31-1930** 9. AGE (In years, last birthday) **41** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife Home** 11. BIRTHPLACE (State or foreign country) **MD** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **John. Strohmer** 14. MOTHER'S MAIDEN NAME **McHenry?**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO.

17. INFORMANT **Records: BCH-4940 Eastern Avenue 21224** ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
**E 8931 X 42509**  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  
**DIABETES**

19A. DATE OF OPERATION **1-6-72** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  
**Wound. Sepsis**  
20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **YES**

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☒ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Home** 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) **1509 McHenry St. 1902**

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) **12 19 71 5:55 AM** 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☒ 21F. HOW DID INJURY OCCUR? **CLOTHES CAUGHT ON FIRE FROM SPACE HEATER**

22. I certify that (1) (this hospital) attended the deceased from **12-20-71** to **1-6-72** that (2) (we) last saw the deceased alive on **1-5-72** and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Francisco Jose Negri MD** 23B. DATE SIGNED **1-6-72**

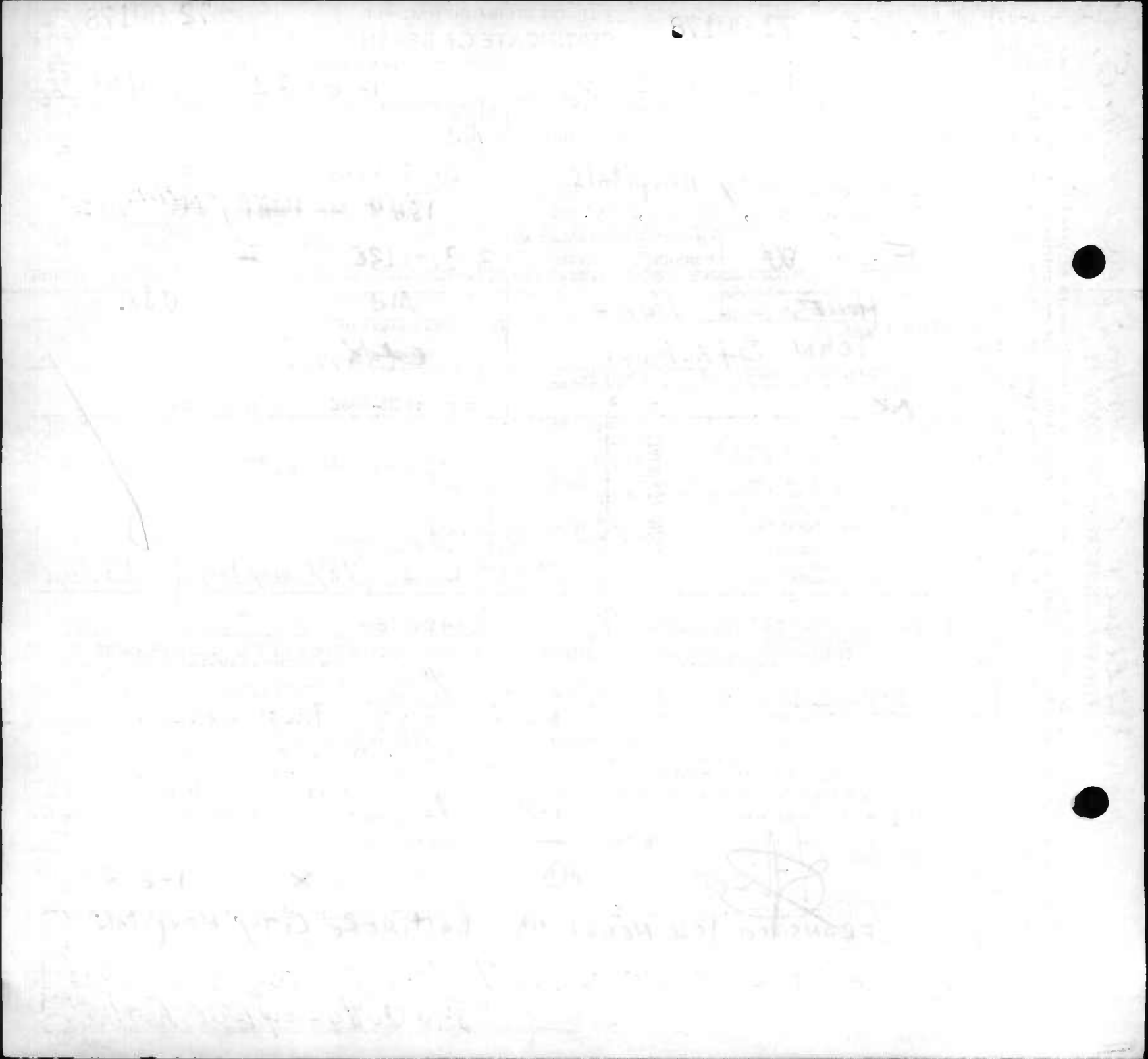
23C. PHYSICIAN'S NAME (Type) **Francisco Jose Negri MD** 23D. ADDRESS **4940 Eastern Avenue, Baltimore, Md. 21224**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **1-10-72** 24C. NAME OF CEMETERY OR CREMATORY **Balto. Natl. Cen. Balto. Md** 24D. LOCATION (City, town, or county) (State) **Balto. Md**

25A. DATE REC'D BY HEALTH DEPT. **JAN 10 1972** 25B. NAME OF REGISTRAR **John E. Kelly** 25C. FUNERAL DIRECTOR **John E. Kelly - ny 130 E. Fort Ave.** ADDRESS **2/230**

Released On Approval by M.C.  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

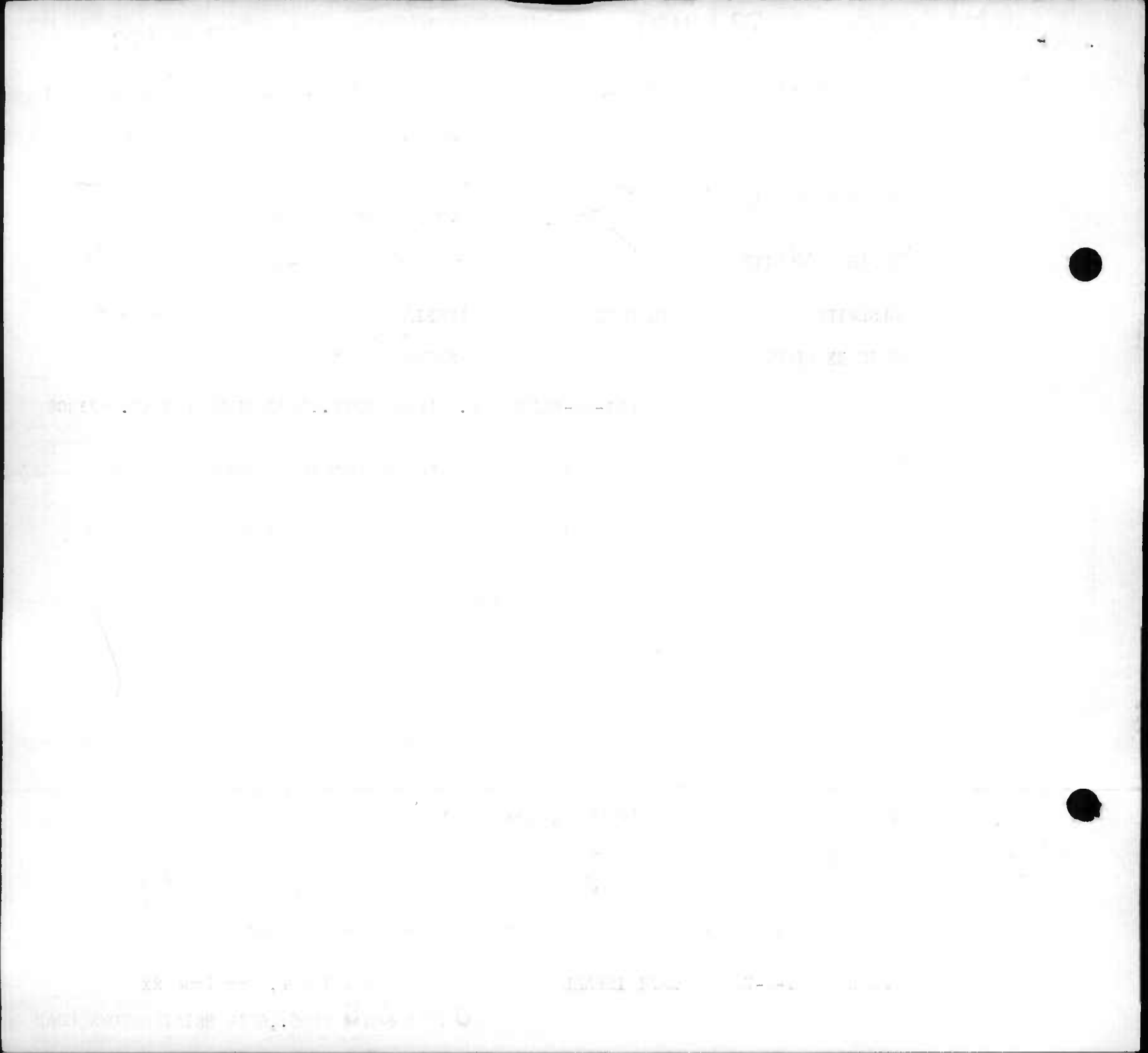




FUNERAL DIRECTOR: IMPORTANT

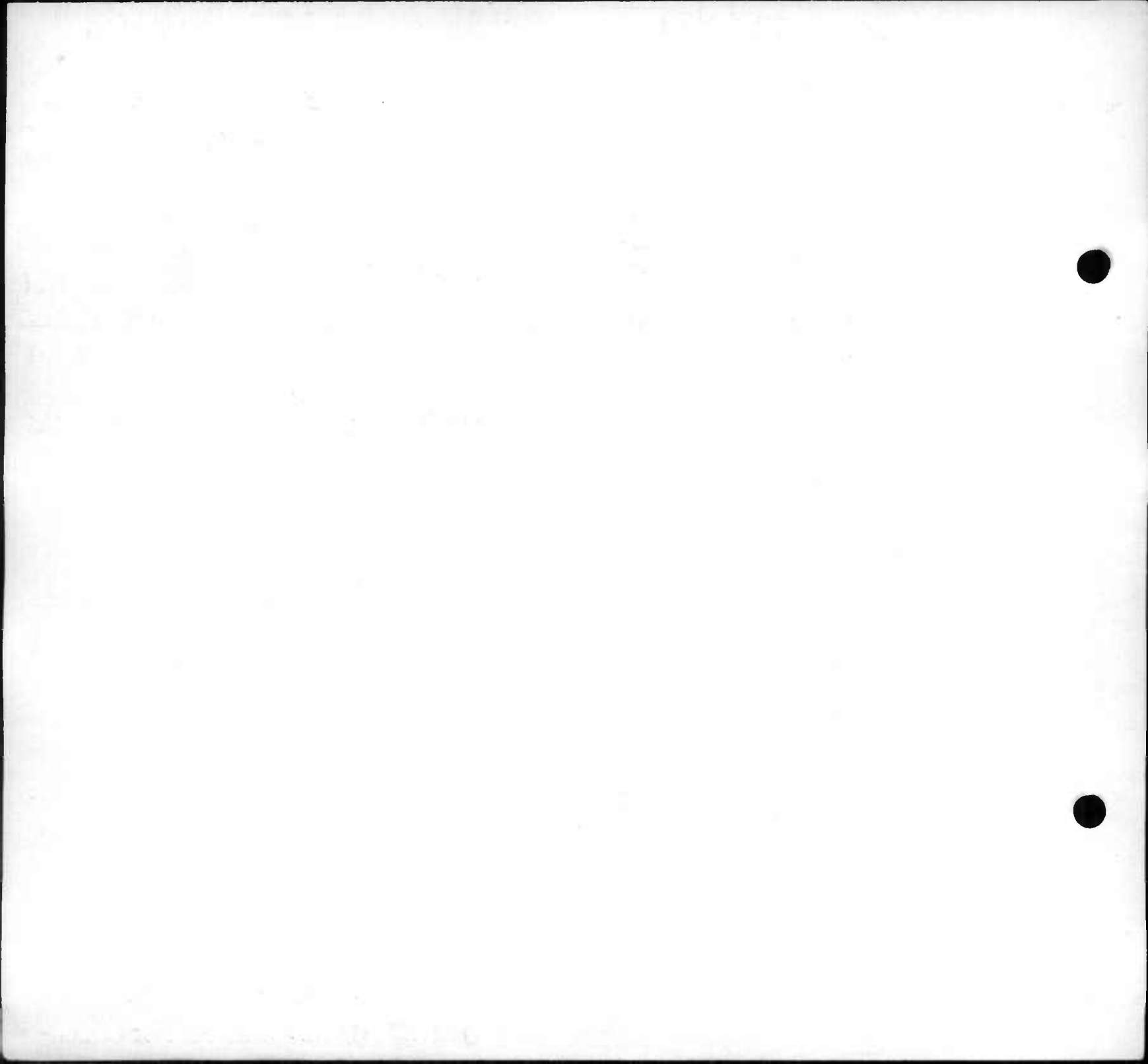
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00176</u>
BIRTH NO. <u>B-260</u>		72 00176		
1. NAME OF DECEASED (Type or Print) <u>ANNA BAKER</u>		2. DATE AND HOUR OF DEATH <u>5 JAN 1972</u> <u>3:40</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL of BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> <u>5300</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3403 Winterset Ct.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-89</u>	9. AGE (in years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
13. FATHER'S NAME <u>LOUIS OLSON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>081-09-8550D</u>		17. INFORMANT <u>MRS. EDWARD CARP., 3403 WINTERSET CT. #21208</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>arteriosclerotic hypertensive cardiovascular disease</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>1-5-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>3:40 AM 5 JAN 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Hector Lopez Jr MD</u>		23B. DATE SIGNED <u>1/5/72</u>		23C. PHYSICIAN'S NAME (Type) <u>HECTOR LOPEZ JR MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-6-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Maryland 21</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		
25B. NAME OF REGISTRAR <u>SOLO LEVINSON &amp; BROS.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>6010 REISTERSTOWN ROAD</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <u>72 00179</u></p>	
<p><b>1. NAME OF DECEASED</b>                  (Type or Print) <u>ARTHUR L. KING</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b>  <u>Jan 5 1972</u> <u>12 35</u> A.M.</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>                  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>BON SECOURS HOSPITAL</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)                  A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>                  C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  E. STREET AND NUMBER <u>333 HARLEM LANE</u></p>	
<p><b>5. SEX</b>  <u>M</u></p>	<p><b>6. RACE</b>  <u>W</u></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b>  <u>6/24/85</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <u>RETIRED</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b>  <u>Scrap Iron &amp; Metal</u></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country)  <u>MARYLAND</u></p>
<p><b>13. FATHER'S NAME</b>  <u>Edward King</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b>  <u>MARIE B.</u></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b>                  (Yes, no or unknown) (If yes, give war or dates of service)  <u>No</u></p>		<p><b>16. SOCIAL SECURITY NO.</b>  <u>215-018882</u></p>	<p><b>17. INFORMANT</b> (Son)  <u>LEWIS KING</u> ADDRESS <u>1710 LETITIA AVE 21230</u></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                  ANTECEDENT CAUSES                  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last</p>		<p><b>CAUSE OF DEATH</b>  <u>Septicemia &amp; hepatic abscess</u>                  (A) IMMEDIATE CAUSE                  DUE TO, OR AS A CONSEQUENCE OF:  <u>Ascending cholangitis</u>                  (B) DUE TO, OR AS A CONSEQUENCE OF:  <u>Carcinoma, head of pancreas</u>                  (C) <u>Aspiration pneumonia. Old post. infarct. days</u></p>	
<p><b>II</b>                  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  <u>Aspiration pneumonia. Old post. infarct. days</u></p>			
<p><b>19A. DATE OF OPERATION</b>  <u>2-29-1971</u></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  <u>NO</u></p>	<p><b>20A. AUTOPSY?</b> (Yes or No)  <u>YES</u></p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  <u>YES</u></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  <u>NO</u></p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  <u>NO</u></p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)                  (APPROX.)  <u>NO</u></p>	<p><b>21E. INJURY OCCURRED</b>                  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b>  <u>NO</u></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>12-29-1971</u> to <u>1-5-1972</u> that (I) (we) last saw the deceased alive on <u>1-4-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b>  <u>BANDITI</u></p>		<p><b>23B. DATE SIGNED</b>  <u>1-5-72</u></p>	<p><b>23C. PHYSICIAN'S NAME</b> (Type)  <u>BANDITI</u></p>
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)  <u>CREMATION</u></p>		<p><b>24B. DATE</b>  <u>1-7-72</u></p>	<p><b>24C. NAME of CEMETERY or CREMATORY</b>  <u>LOLTON PARK CEMETERY</u></p>
<p><b>24D. LOCATION</b> (City, town, or county) (State)  <u>3801 FREDRICK AVE BALTO, MD.</u></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b>  <u>JAN 10 1972</u></p>	
<p><b>25B. NAME OF REGISTRAR</b>  <u>Robert C. Taylor, M.D.</u></p>		<p><b>25C. FUNERAL DIRECTOR</b>  <u>Mc Guffey, 237 PATARCO AVE 21225</u></p>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH SHIMANEK (Shinnick)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>January</b> Day <b>6</b> , Year <b>1972</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 829 N. Patterson Park</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>6</b> , Year <b>1972</b>		Hour <b>12:30 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>June 2, 1889</b>		10. AGE (In years last birthday) <b>82</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>USA</b>		13. FATHER'S NAME <b>John Shumanek</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>	
15. MOTHER'S MAIDEN NAME <b>Josephine BENDA</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>716123737</b>	
18. INFORMANT <b>Mary F. Shumanek</b>		19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. DATE OF OPERATION <b>0</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>829 N. Patterson Park</b>		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>829 N. Patterson Park</b>	
24. TIME OF INJURY (APPROX.) <b>4:12 P.M.</b>		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR? <b>Arteriosclerotic cardiovascular disease</b>	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <b>Charles S. Springate, M.D.</b>		29. DATE SIGNED <b>January 6, 1972</b>	
30. ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		31. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		32. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		34. 24B. DATE <b>1-8-72</b>		35. 24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
36. 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		37. 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		38. 25B. NAME OF REGISTRAR <b>Robert C. Fisher, M.D.</b>	
39. 25C. FUNERAL DIRECTOR <b>1211 Chesapeake Ave.</b>		40. ADDRESS <b>1211 Chesapeake Ave.</b>		41. VS 151-REV. 1/1/68	

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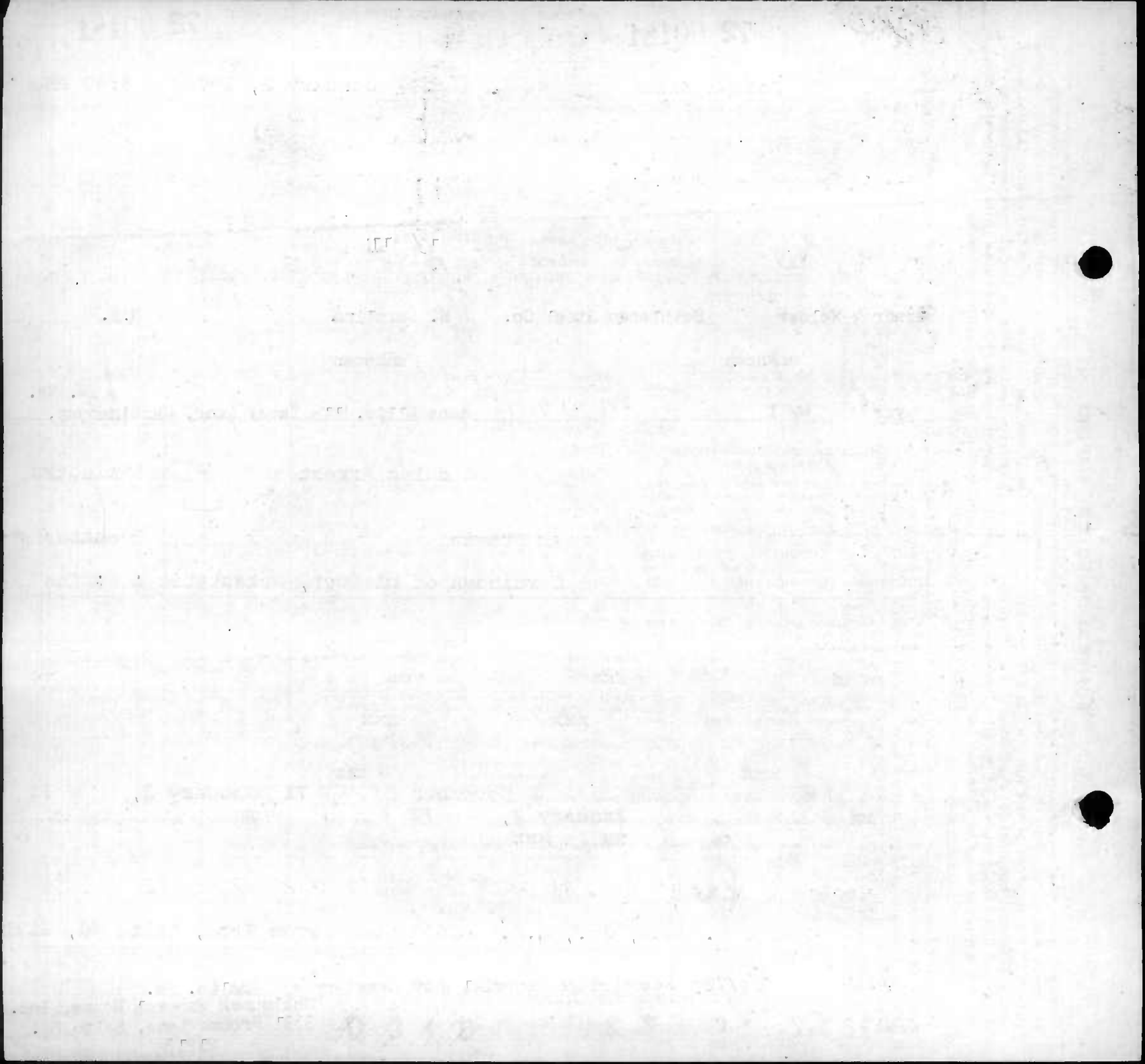
10-11-20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00181</u>	
E-420 72 00181		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph Ellis		January 2, 1972 6:00 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  Good Samaritan Hospital 45		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
				B. COUNTY BALTO	
		C. CITY OR TOWN Lansdowne		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Kessler Ct. 3310			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-98	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner & Welder		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) N. Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 217-07-9674		17. INFORMANT Anna Ellis, 113 Tammy Lane, Martinsburg, W. Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  I  CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cadiac Arrest 5 minutes  (B) Uremia 2 months  (C) Carcinoma of bladder, metastatic 6 months		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED xxx		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) xxx		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) xxx	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) xxx		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? xxx	
22. I certify that (he) (this hospital) attended the deceased from November 9, 1971 to January 2, 1972, that (I) (we) last saw the deceased alive on January 2, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Sack, Jr., M.D.				23B. DATE SIGNED 1/2/72	
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.				23D. ADDRESS 5600 Loch Raven Blvd, Balto Md, 2121	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/6/72		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park Cemetery	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR Schimunek Funeral Homes, Inc.			
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR Robert E. Sack, Jr.		25C. FUNERAL DIRECTOR 3331 Brehms Lane, Balto Md.	



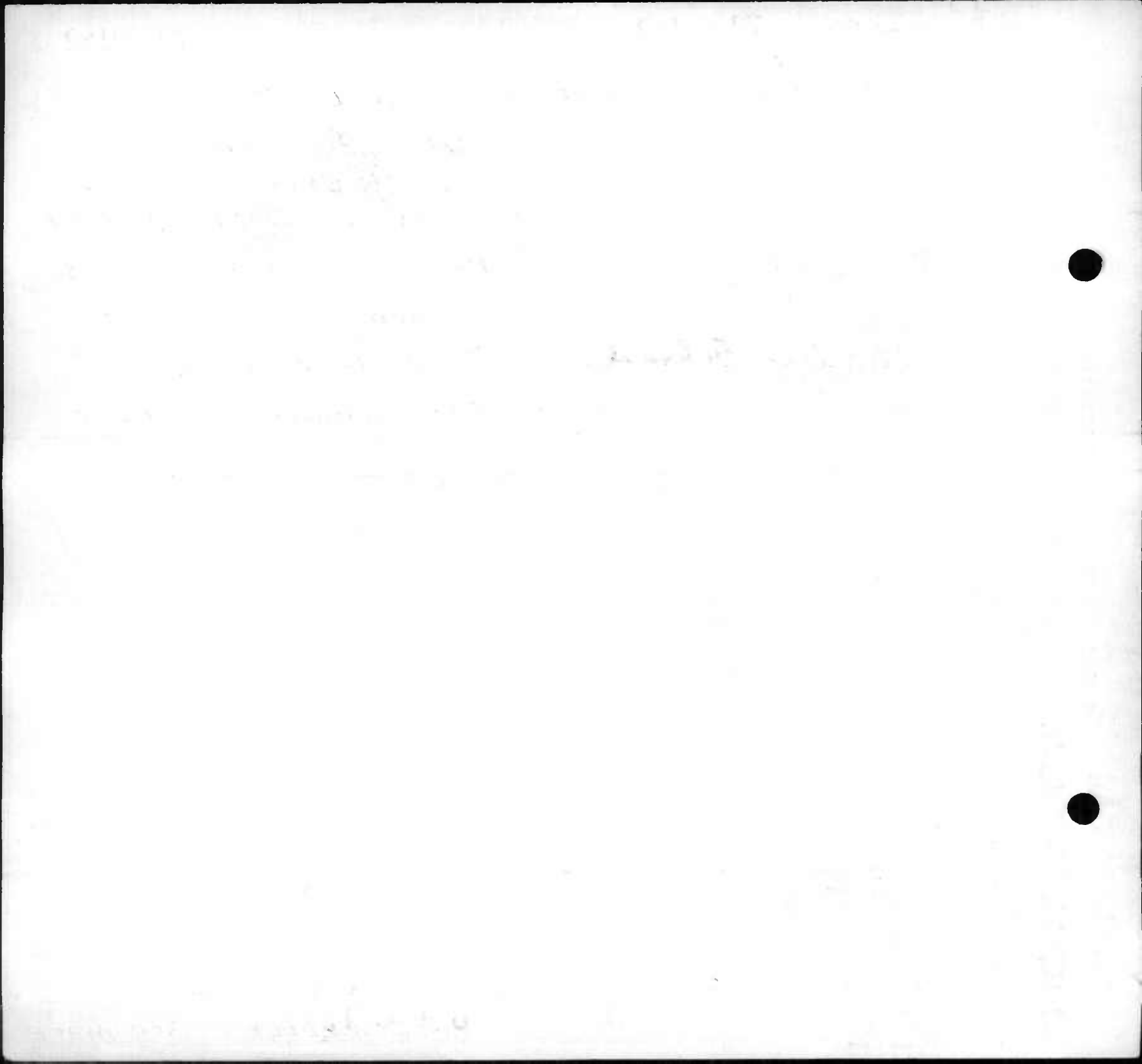




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-620 72 00182		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00182 4	
BIRTH NO. 72-00198				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby GIRL MARIE SCHRACK				1/4/72 11:15 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sina Hospital				A. STATE Md. BALTO 5300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTO ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 1608 Riverwood Rd. # 21			
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/72	9. AGE (In years last birthday) HB	10. Under 1 Yr. Months Days 10 30	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Schrack				14. MOTHER'S MAIDEN NAME Marie BOWERSOX			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CHAS. SCHRACK		ADDRESS ABOVE	
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: respiratory arrest (B) Myaline Membrane DUE TO, OR AS A CONSEQUENCE OF: ? (C) Sepsis			
19. 776.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 4 1972 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. G. Connelly				23B. DATE SIGNED 1/4/72		23C. PHYSICIAN'S NAME (Type) EMMALINA GOLEZ	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/6/72		24C. NAME OF CEMETERY or CREMATORY HOLLY HILL		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR J. G. CONNELLY		25C. FUNERAL DIRECTOR J. G. CONNELLY		ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

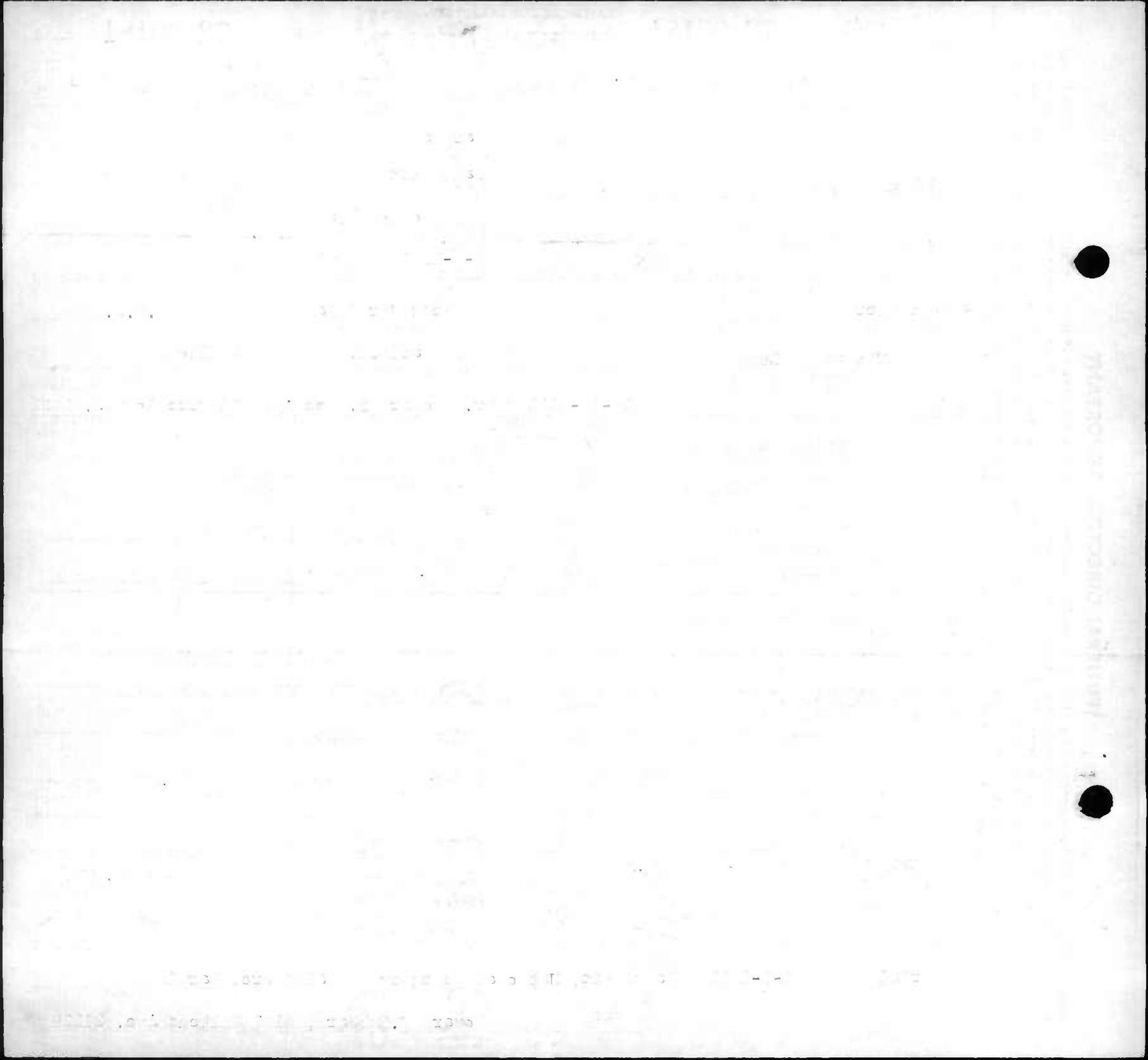
C-456		72 00183		BALTIMORE CITY HEALTH DEPARTMENT		X		72 00183	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH							
Charles E. Chalmers Sr.		1-5-72				7:49 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY							
46 Lutheran		Maryland. Balto. Co.				5300			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
		Woodlawn		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
		E. STREET AND NUMBER							
		2310-Birch, D.U.							
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months: Days: Hours: Min.	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-24-97		74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Electrical Contractor		Electrical		Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
?		?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		216 12 2841		Charles E. Chalmers Jr.		1120 Wedgewood Rd.			
18. 427.01		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE				9 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		Chronic Brain Syndrome							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		Congestive Heart failure							
		(C) _____							
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from		12-28		19 71 to		1-5-19 72			
that (I) (we) lost saw the deceased alive on		1-5		19 72 and that (my) (our) opinion death occurred on the date					
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		23B. DATE SIGNED							
D.S. Karbhari		1-5-72							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
D.S. KARBHARI MD		Lutheran Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1-8-72		Woodlawn Cem.		Woodlawn, Balto. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 10 1972		John T. Stansbury		6411 Windsor Mill Rd.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00184	
72 00184					
BIRTH NO. 11-240					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MRS. RUTH A. WEEKLY			JAN-5-1972 10 <sup>40</sup> A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 EDGEMOOD NURSING HOME			Maryland 2844		
5. SEX 7. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9. AGE (In years last birthday) 10. BIRTHPLACE (State or foreign country)		
F W			9-9-1897 74 West Virginia		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Homemaker			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Long			Charlotte Hamilton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			216-40-1171		
17. INFORMANT			ADDRESS		
Mr. Richard P. Weekly, 421 Greenlow Rd, 21228					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
E-9471X			Intestinal Necrosis-		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
II			Infection - complication from		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) TANTALUM Mesh Hernia REPAIR		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Infectious medical examined)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			12/27 1971 to 1/5 1972		
22. I certify that (I) (this hospital) attended the deceased from 1-4-1972 and that in (my) (our) opinion death occurred on the date end hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Anthony F. Carozza			1-5-1972		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Anthony F. CAROZZA MD			5217 YORK RD BALTO MD 21212		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1-7-1972		Baltimore, National Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 10 1972		Howard H. Hubbard		4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00185		REG. NO.	
BIRTH NO. <u>B-400</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Ernest L. Bell. (Also Turner Bell)</u>				2. DATE AND HOUR OF DEATH <u>1/5/72 11:00 a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>South Baltimore General Hospital.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3211 Janice Ave.</u>		21227	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/76</u>	9. AGE (in years last birthday) <u>95</u>	10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Maintenance Man</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Bell</u>				14. MOTHER'S MAIDEN NAME <u>Jane Townsend</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-26-4955</u>		17. INFORMATION TOWN AND ADDRESS <u>R. Sirithara, South Baltimore General Hospital</u>	
18. <u>56041</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Small bowel obstruction - adhesion</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>with Heart block.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Post-operative Small bowel obstruction</u> (C) <u>Small bowel obstruction - adhesion</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Small bowel obstruction - adhesion</u>							
19A. DATE OF OPERATION <u>1/2/8/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>intestinal obstruction</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (H) (this hospital) attended the deceased from <u>12-6-1971</u> to <u>1-5-1972</u> that (I) (we) last saw the deceased alive on <u>1-5-1972</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. Sirithara</u>				23B. DATE SIGNED <u>1/5/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>SIRITHARA</u>				23D. ADDRESS <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-8-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Sirithara</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	

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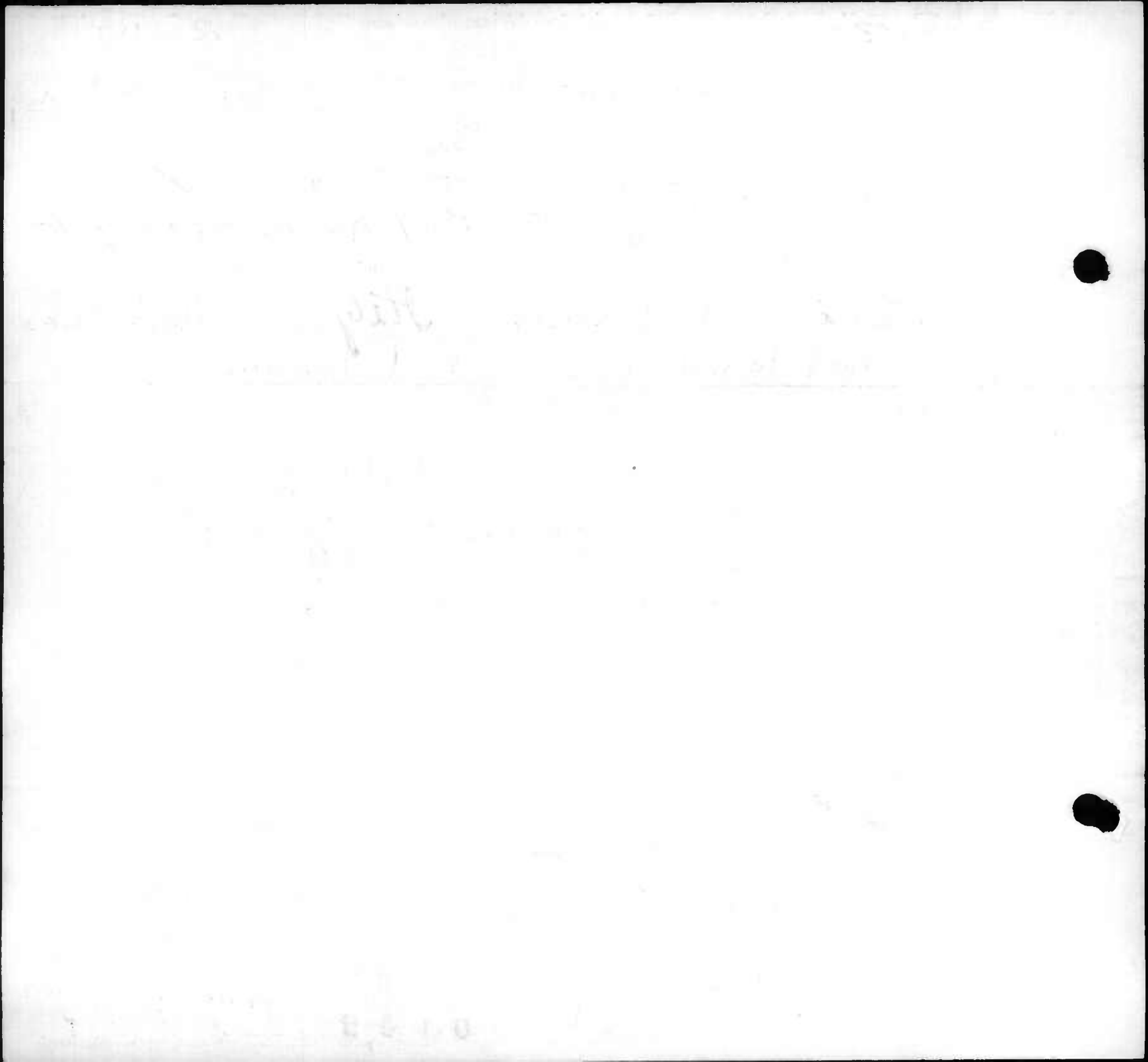
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

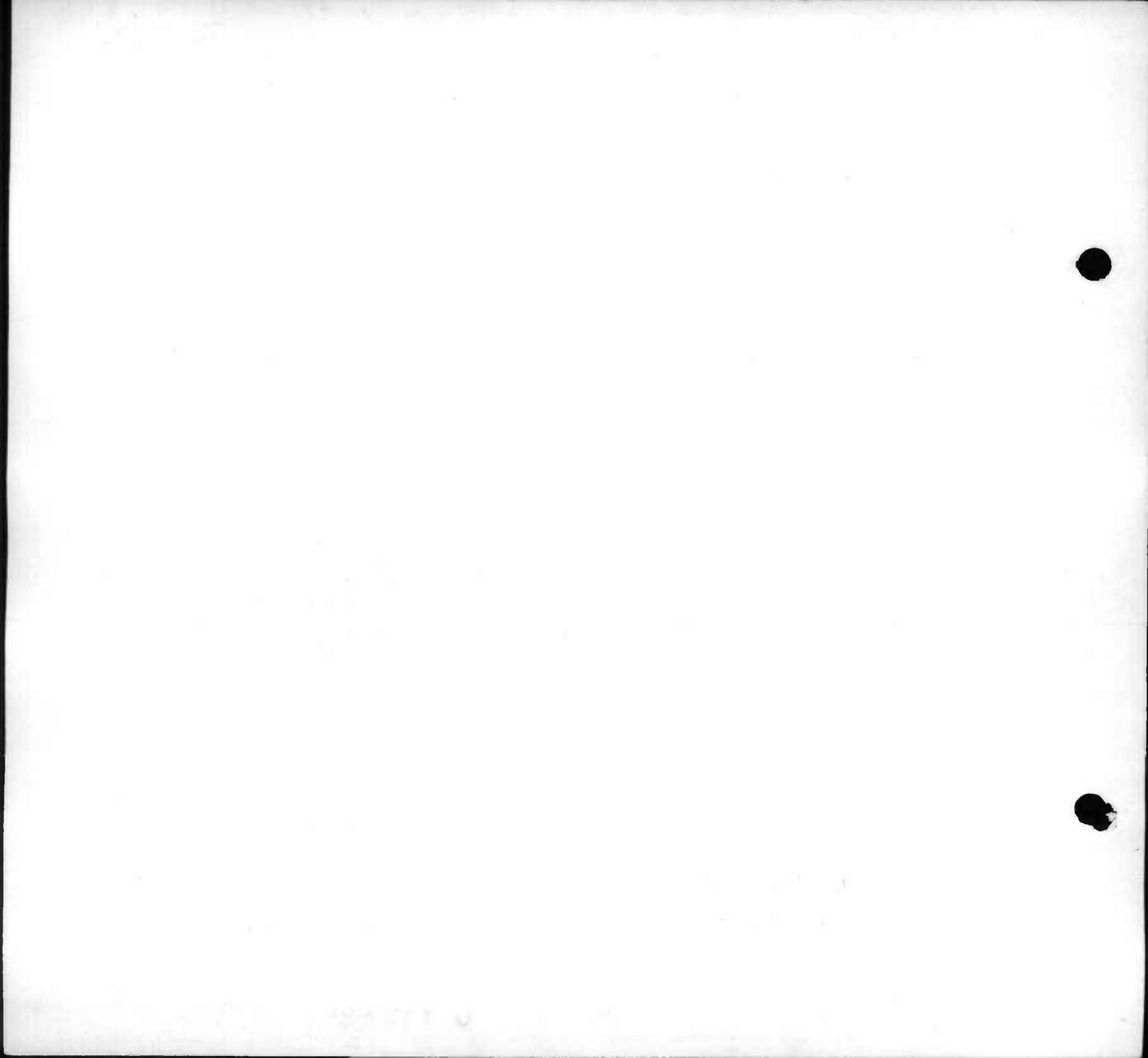
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">S-230</span> <span>72 00186</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.5em;">72 00186</span>	
BIRTH NO. <span style="font-size: 1.5em;">72 00186</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">SACCHETTI BART NMN</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">1-5-1972 6.35 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">No. CHARLES GEN. HOSP. 49 BARTO-MD. 2118</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.5em;">MD</span> B. COUNTY <span style="font-size: 1.5em;">2748</span>		C. CITY OR TOWN <span style="font-size: 1.5em;">Cat Creek</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.5em;">M</span> 6. RACE <span style="font-size: 1.5em;">W</span> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">10-20-1903</span> 9. AGE (In years last birthday) <span style="font-size: 1.5em;">68</span> 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Italy</span> 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">United States</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Retired</span> 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">mill-workmen</span>		13. FATHER'S NAME <span style="font-size: 1.5em;">not known</span> 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">not known</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span> 16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">169-05-5236</span> 17. INFORMANT <span style="font-size: 1.5em;">MARY SACCHETTI - Spouse</span> ADDRESS <span style="font-size: 1.5em;">1505 Sherwood Ave</span>	
18. <span style="font-size: 1.5em;">410.8 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Ant. M.I. &amp; Pneumonia Rt. Lung</span> (B) CHF, Cardiomyopathy, CVA DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">&amp; ASECVD</span> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">NO</span> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that <del>if</del> (this hospital) attended the deceased from <span style="font-size: 1.5em;">1-2-1972</span> to <span style="font-size: 1.5em;">1-5-1972</span> that (I) <del>we</del> last saw the deceased alive on <span style="font-size: 1.5em;">1-5-72</span> 19 and that (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. <del>if</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span> 23B. DATE SIGNED <span style="font-size: 1.5em;">1-5-72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Dr. KRULEVITZ (Attending Phys.)</span> 23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span> 24B. DATE <span style="font-size: 1.5em;">1-8-72</span> 24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Queen of Heaven</span> 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Mt Murray Washington Penna</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JAN 10 1972</span> 25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">[Signature]</span> 25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">[Signature]</span> ADDRESS <span style="font-size: 1.5em;">[Signature]</span>					



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00187</u> <u>4</u>	
R-236 <u>72 00626</u> <u>72 00187</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl ROYSTER</u>			2. DATE AND HOUR OF DEATH <u>1-4-72</u> <u>9:20 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2864</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4304 ADELLE TERRACE - APT. 301</u>		
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-72</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days <u>11</u> <u>20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>THOMAS ROYSTER</u>			14. MOTHER'S MAIDEN NAME <u>THERESA LUCILLE LINDSAY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>776.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Atelectasis of lungs</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Petechial hemorrhages of pleura + pericardium, secondary to asphyxia</u> <u>Status post breech presentation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>hours</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>1/3 1972</u> to <u>1/4 1972</u> that <u>it</u> (we) lost saw the deceased alive on <u>1/4 1972</u> and that <u>in</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>it</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dhara Pongsiri</u>			23B. DATE SIGNED <u>1/4/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>DHARA PONGSIRI</u> M.D.			23D. ADDRESS <u>Bon Secours Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>1/4/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Bon Secours Hospital</u>	
24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>			
25B. NAME OF REGISTRAR <u>John E. Smith</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

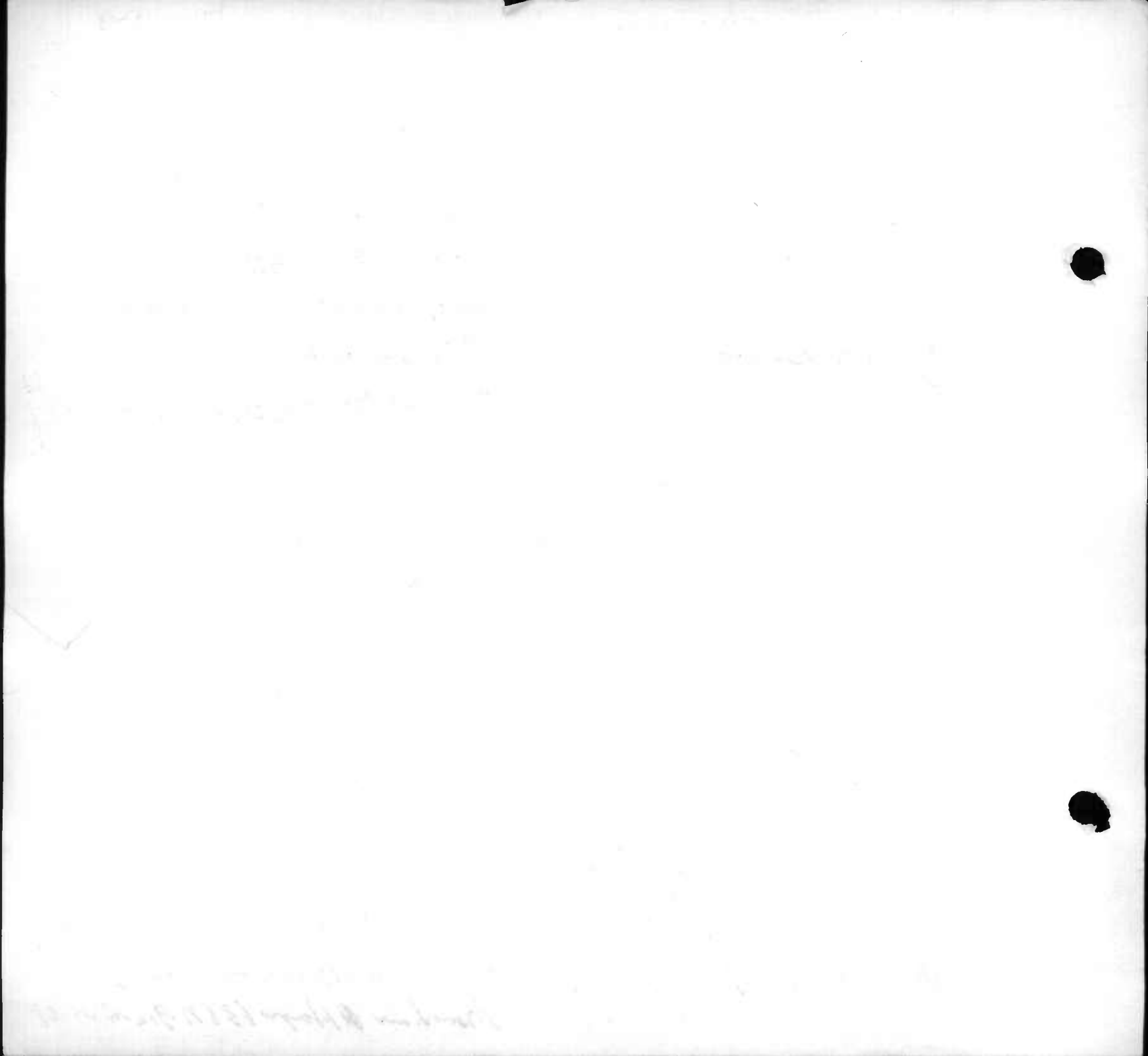
BIRTH NO. <u>D-120</u> <u>72 00188</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>12 00188</u>	
1. NAME OF DECEASED (Type or Print) <u>ROBERT L. DAVIS</u>				2. DATE AND HOUR OF DEATH <u>JAN. 6, 1972</u> <u>2:30</u> <u>A. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 2 E. HIGHFIELD RD. 2/14/72</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>6/6/81</u>		9. AGE (In years last birthday) <u>90</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLANT GENETICIST</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>COLUMBIA, S. C.</u>	
13. FATHER'S NAME <u>Ellery Williams Davis</u>				14. MOTHER'S MAIDEN NAME <u>Annie Wright</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>423-60-1753</u>		17. INFORMANT <u>Thorsby, Alabama</u> ADDRESS <u>35171 Mrs. Robert L. Davis, 124 Summit St.</u>	
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>atherosclerosis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>OCT. 1956</u> to <u>1-6-1972</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>1-5-1972</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>Frank W. Davis Jr.</u>				23B. DATE SIGNED <u>1-7-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>FRANK W. DAVIS JR. M.D.</u>				23D. ADDRESS <u>11 E. CHASE ST. BALTO., MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/6/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS UNIV.</u>		24D. LOCATION (City, town, or county) (State) <u>709 N. WOLFE ST. BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>REC'D. 1-10-72</u>		25C. FUNERAL DIRECTOR <u>ED. L. SCHWAB</u>		ADDRESS <u>2101 FREDERICK AVE.</u>	

2/16/72 - Letter from decedent's wife, Mrs. Robert L. Davis, 417 N. Thomas St., Apt. 3  
Arlington, Virginia 22203. *ABC.*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

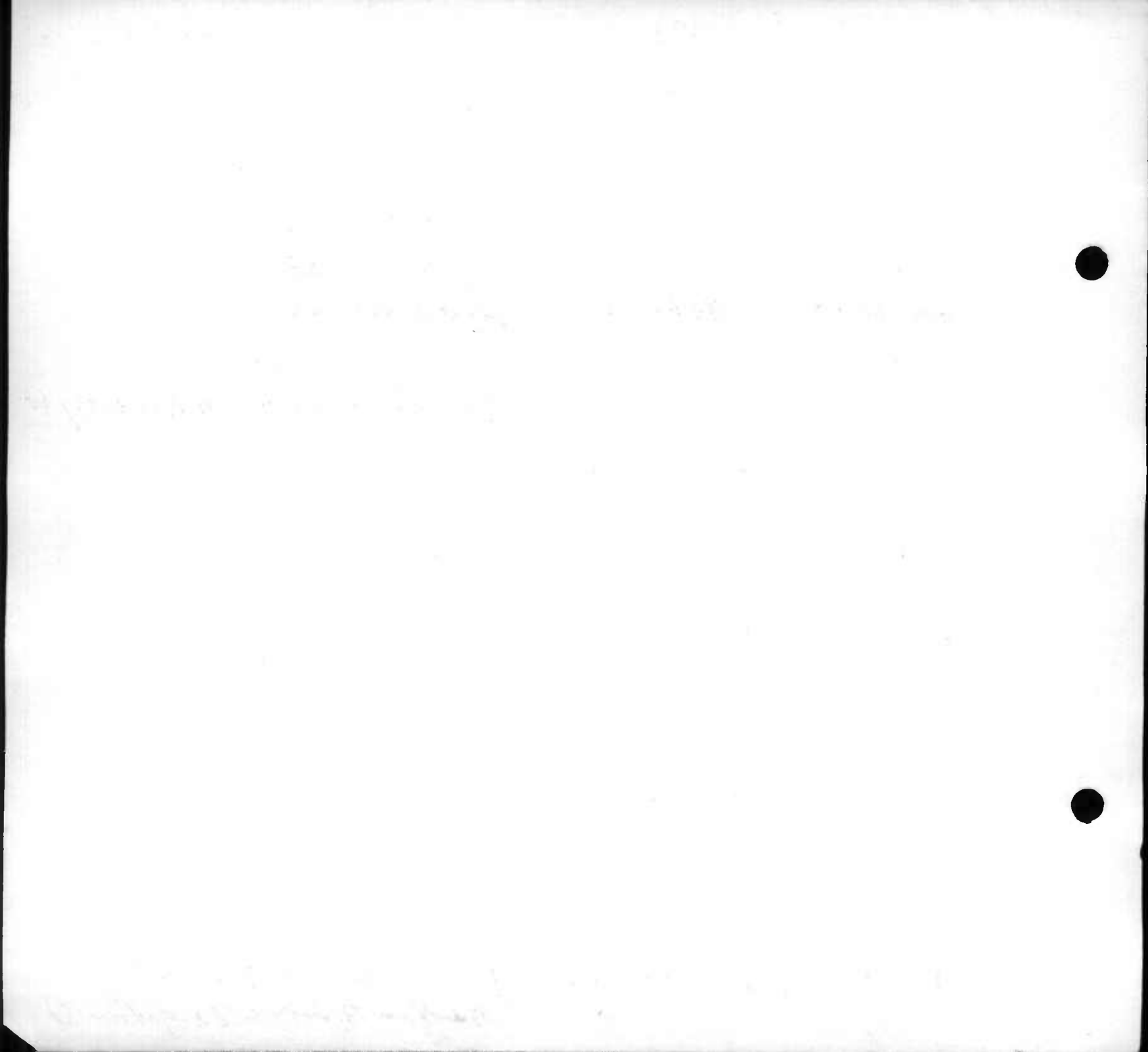
B-400 72 00189 BALTIMORE CITY HEALTH DEPARTMENT				72 00189	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BELL, LAWYER		1/8/72 11:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hosp.			A. STATE MD		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 1901		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1309 W. Mulberry St.		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-24	9. AGE (in years last birthday) 47	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Williamston NC		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jack Boul			14. MOTHER'S MAIDEN NAME Dora Lee		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Carrick Boul 1309 W. Mulberry St
18. 571.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hepatic coma		2 mos
			(B) hepatic cirrhosis DUE TO, OR AS A CONSEQUENCE OF:		4 yrs
			(C) chronic alcoholism		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Renal failure		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/8/72 19 to 1/8 1972 that (I) (we) last saw the deceased alive on 1/8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Faulkner				23B. DATE SIGNED 1/8/72	
23C. PHYSICIAN'S NAME (Type) Dr. GAKUBA				23D. ADDRESS 827 Linden Ave, Balto, 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1/13/72		24C. NAME OF CEMETERY OR CREMATORY Familly Plot	
24D. LOCATION (City, town, or county) (State) Williamston N.C.		25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Esq.	
25C. FUNERAL DIRECTOR W. H. Hays		25D. ADDRESS 638 N. 9th St. S.E.			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

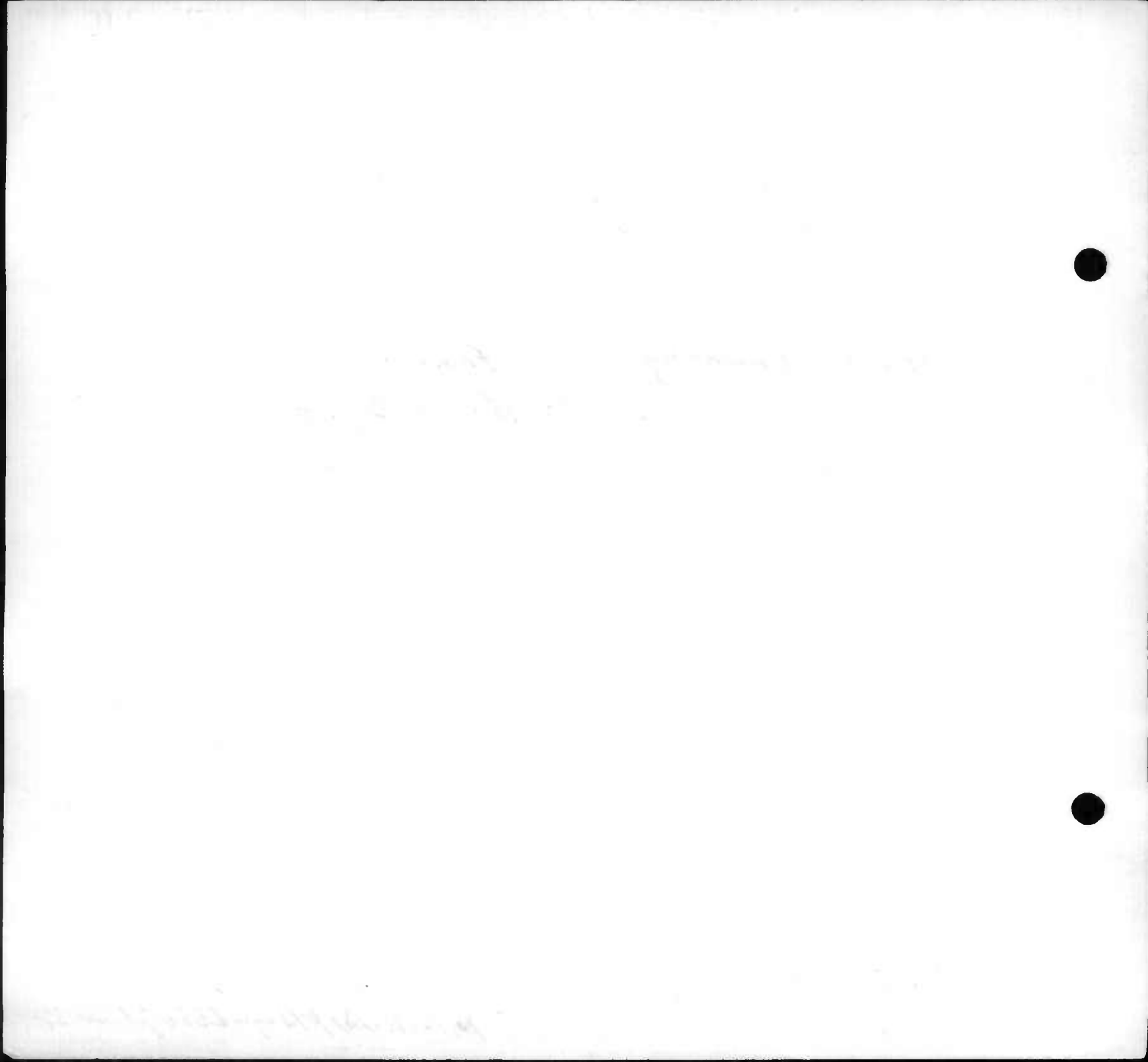
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00190</u>
BIRTH NO. <u>J-250</u>		72 00190		
1. NAME OF DECEASED (Type or Print) <u>Mr. James Jackson</u>		2. DATE AND HOUR OF DEATH <u>1/9/72</u> <u>3:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1901</u>		
5. SEX <u>Male</u>		6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/18</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>R.O.P.R.</u>		9. AGE (In years last birthday) <u>53</u>
13. FATHER'S NAME <u>Leonard Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Greithia C. Cain</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ross Jackson 1423 W. Mulbury St</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>4/12/41-250.9</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cardiac arrhythmia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Uncontrolled diabetes, D.T's.</u>				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Baltimore city</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>12/15/71 - 5A.M.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Heavy drinking - fell down.</u>
22. I certify that (H) (this hospital) attended the deceased from <u>12/16</u> 19 <u>71</u> to <u>1/9</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>1/9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Arvora Ne Bichairon Arone</u> H.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/9/72</u>
23C. PHYSICIAN'S NAME (Type) <u>ARVORA NE BICHAIRON ARONE</u> MD DEGREE		23D. ADDRESS <u>BON SECOURS HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/14/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>St. Lawrence</u>		24D. LOCATION (City, town, or county) (State) <u>Bon Secours MD 21225</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Fisher</u> ADDRESS <u>638 N. G. St. NW</u>



# FUNERAL DIRECTOR: IMPORTANT

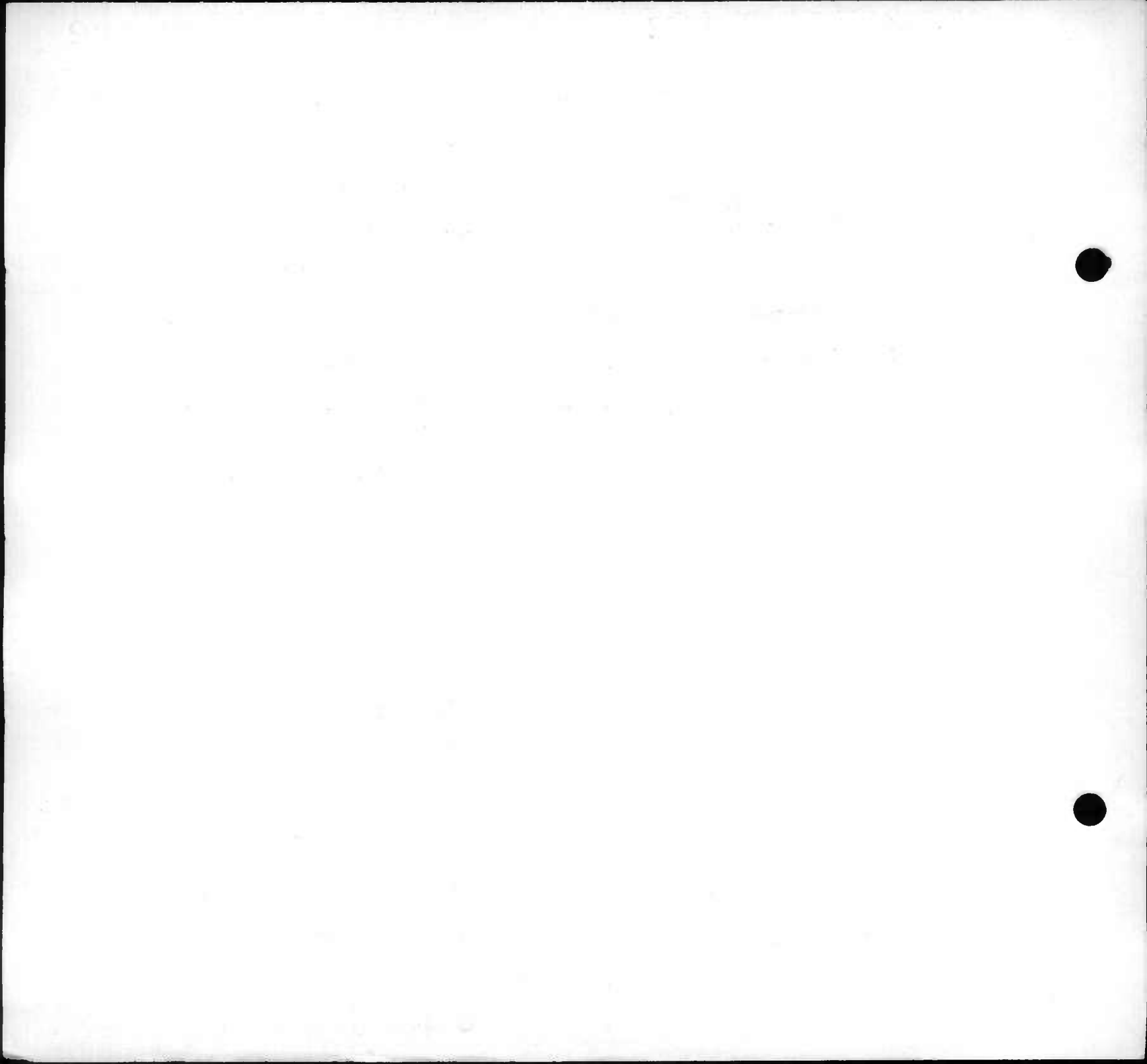
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-530 72 00191		BALTIMORE CITY HEALTH DEPARTMENT		72 00191	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>CANNADY, HERBERT</b>			2. DATE AND HOUR OF DEATH <b>1-6-72 9:30 PM.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL of BALTIMORE BELVEDERE GREENSPRING</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2802</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4178 Fount Park Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>Ny</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/23/39</b>	9. AGE (in years last birthday) <b>32</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Herbert Cannady</b>			14. MOTHER'S MAIDEN NAME <b>Frances</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-34-3794</b>	17. INFORMANT ADDRESS <b>Frances Bayant, 4021 KORNHARDT AVE</b>		
18. <b>571.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Circulation of the heart</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Ischemic myocardial infarction</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>1/5/72</b> 19 to <b>1/6</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/6/72</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Anacleto T. Ordinario, Jr. MD</b>			23B. DATE SIGNED <b>1-6-72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>ANACLETO T. ORDINARIO JR. MD</b>			23D. ADDRESS <b>SINAI HOSPITAL of BALTIMORE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>1/11/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MT RAINIER</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore P/H Agency 2354 Johnson St</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

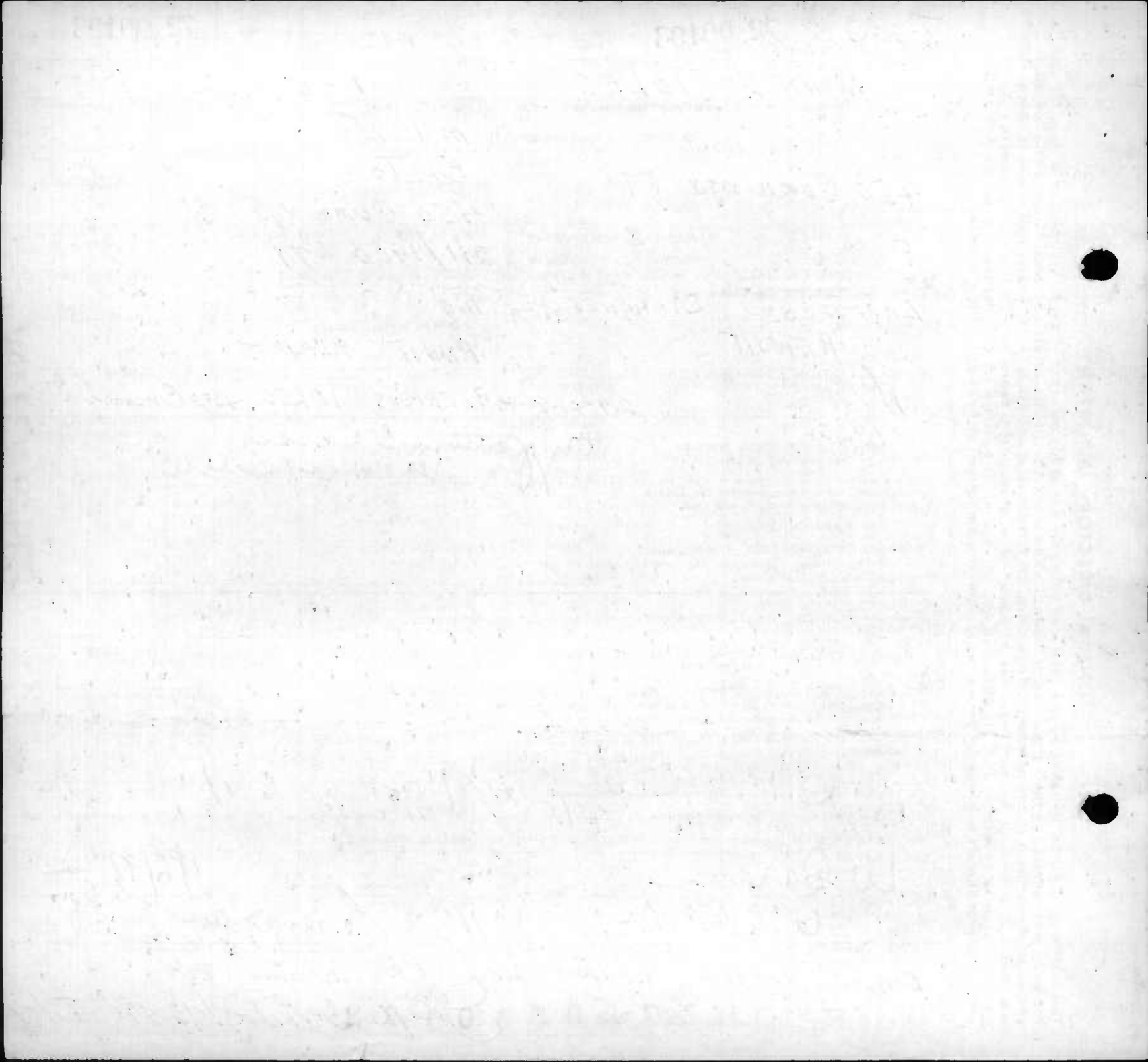
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">72 00192</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Carrie Bourghs		1/6/72 2 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
90 Kenson Nursing Home 2922 Arunah Ave			Md		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2922 Arunah Ave		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	C	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		103	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
none			none		Virginia
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Bourghs			Lucy Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			212-56-5943		MRS GRIMES, 1829 Riggs Ave
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Cardio-Vascular Disease	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				none	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 none		none		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1960 to Jan. 6, 1972 that (I) (we) last saw the deceased alive on Jan. 6, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frank N. Ogden, M.D.				Jan. 8, 1972	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANK N. OGDEN, M.D.		2701 N. Calvert St Balto. Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/8/72		Mt Calvary Cemetery	
		24D. LOCATION		(City, town, or county) (State)	
		A A County		Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 10 1972		Robert E. Fisher, M.D.		Adolphus Halstead 1206 W North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00193	
T-420 72 00193		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MINNIE TOLES		2. DATE AND HOUR OF DEATH 1-5-72 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		1702	
FULL NAME OF HOSPITAL OR INSTITUTION 450 CUMMINGS CT		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 450 CUMMINGS CT		5. SEX F		6. RACE C	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/1900		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRESS		10B. KIND OF BUSINESS OR INDUSTRY ST. AGNES Hosp		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME HEWITT		14. MOTHER'S MAIDEN NAME ANNIE READER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO. 219-01-8019A		17. INFORMANT AMERICUS TOLES 450 Cummings Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.2 I DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Extensive Cardio Vascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased, from 1/10/58 to 1/5/72, that (I) (we) last saw the deceased alive on 12/20/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Garner		23B. DATE SIGNED 1/6/72			
23C. PHYSICIAN'S NAME (Type) W. GARNER		23D. ADDRESS 1133 Penna ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/8/72		24C. NAME OF CEMETERY or CREMATORY Arbutus mem. PK	
24D. LOCATION (City, town or county) (State) Arbutus, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR Blair J. ...	
25C. FUNERAL DIRECTOR Joseph B. Lock		25D. ADDRESS 1304 N Central Ave			



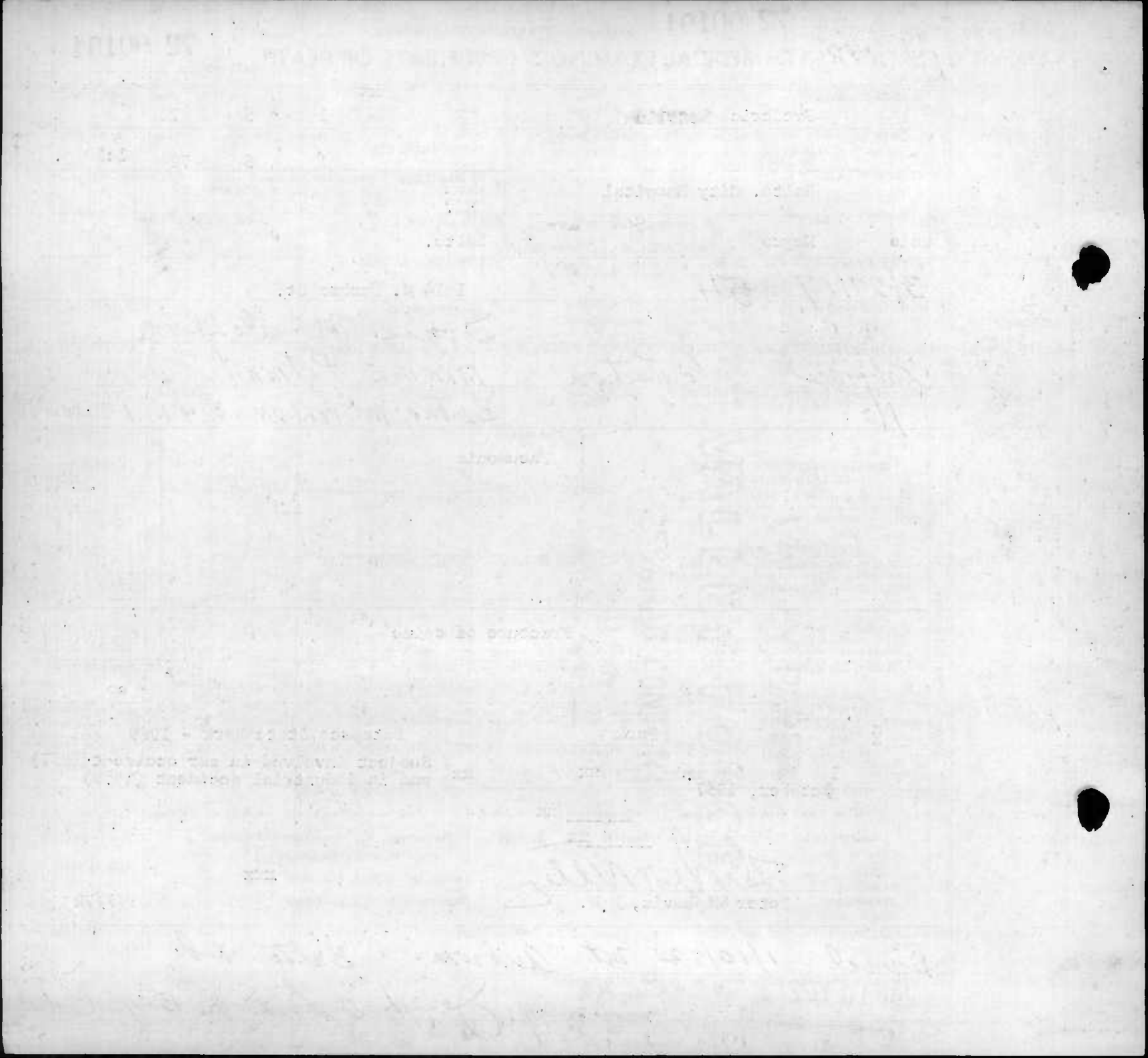


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Frederick McCollum</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>5</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Balto. City Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>5</b> Year <b>72</b> Hour <b>3:30 p. M.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3/27/17</b>		10. AGE (In years last birthday) <b>54</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Space Mc Collum</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE PITMAN</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO.	
19. <b>E 946X</b>		CAUSE OF DEATH <b>Pneumonia</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>Fracture of spine</b>	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Park</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Patapsco State Park - 1969 5200</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>1 14 69 unk m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject involved in car accident (1957) and in industrial accident (1969)</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1/7/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph G. Locks</b>		ADDRESS <b>1304 N. Central</b>	



P-230

72 00195

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00195

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Leo Paquette</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 3 72 1:48 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>819 W. Madison Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year 1 3 72 1:48 P.M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1701</b>	
9. DATE OF BIRTH <b>3 Sept. 1892</b>		10. AGE (in years lost birthday) <b>79</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester, Mass.</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217 54 1721</b>	
17. INFORMANT		18. ADDRESS <b>Albert Ingelfinger 815 Madison Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Saitz, M.D.</b> DATE SIGNED <b>1-4-72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/7/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Mary-E. Law</b>		25D. ADDRESS <b>802 Madison Ave.</b>	

FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

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98. [Illegible]

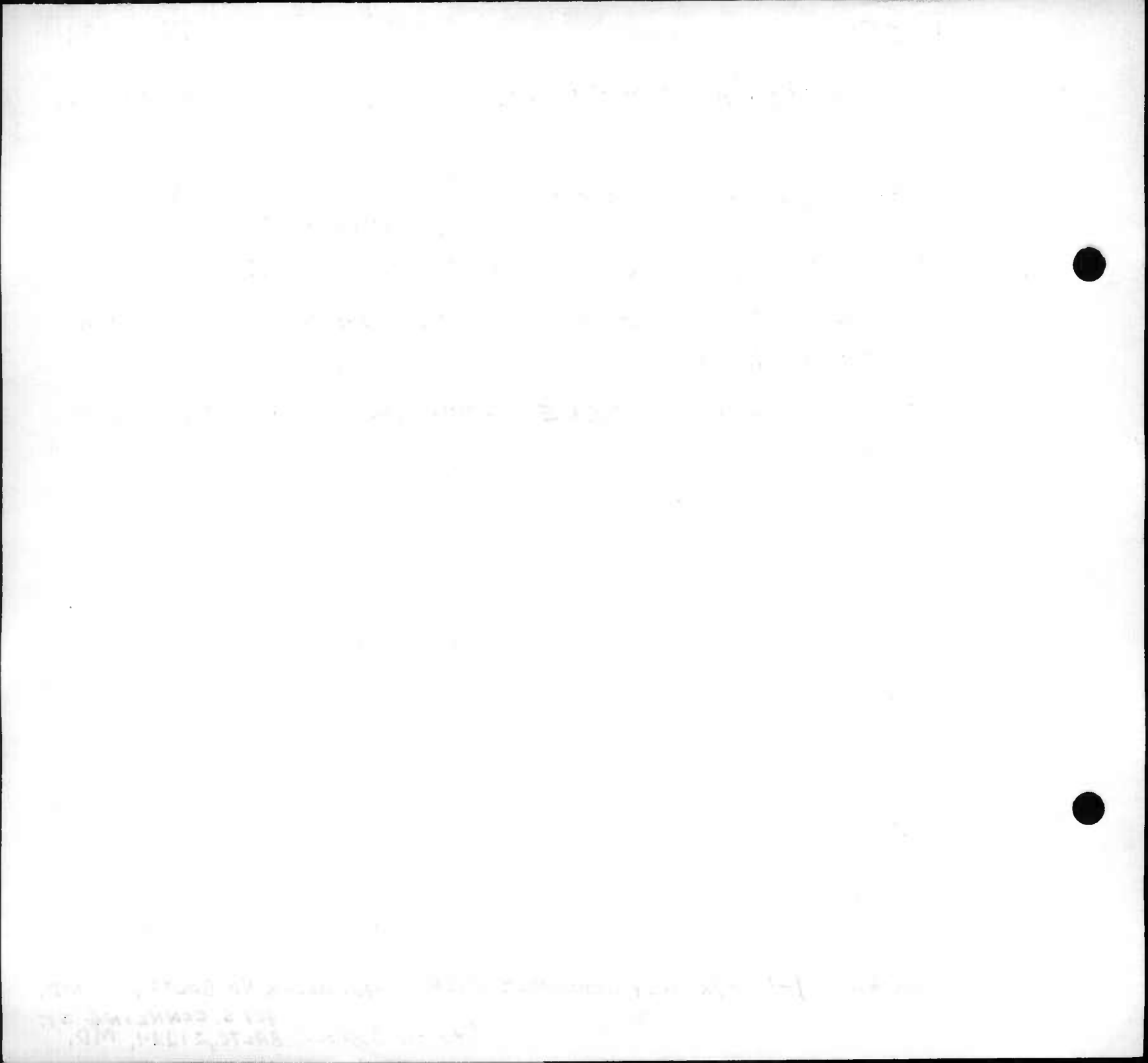
99. [Illegible]

100. [Illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

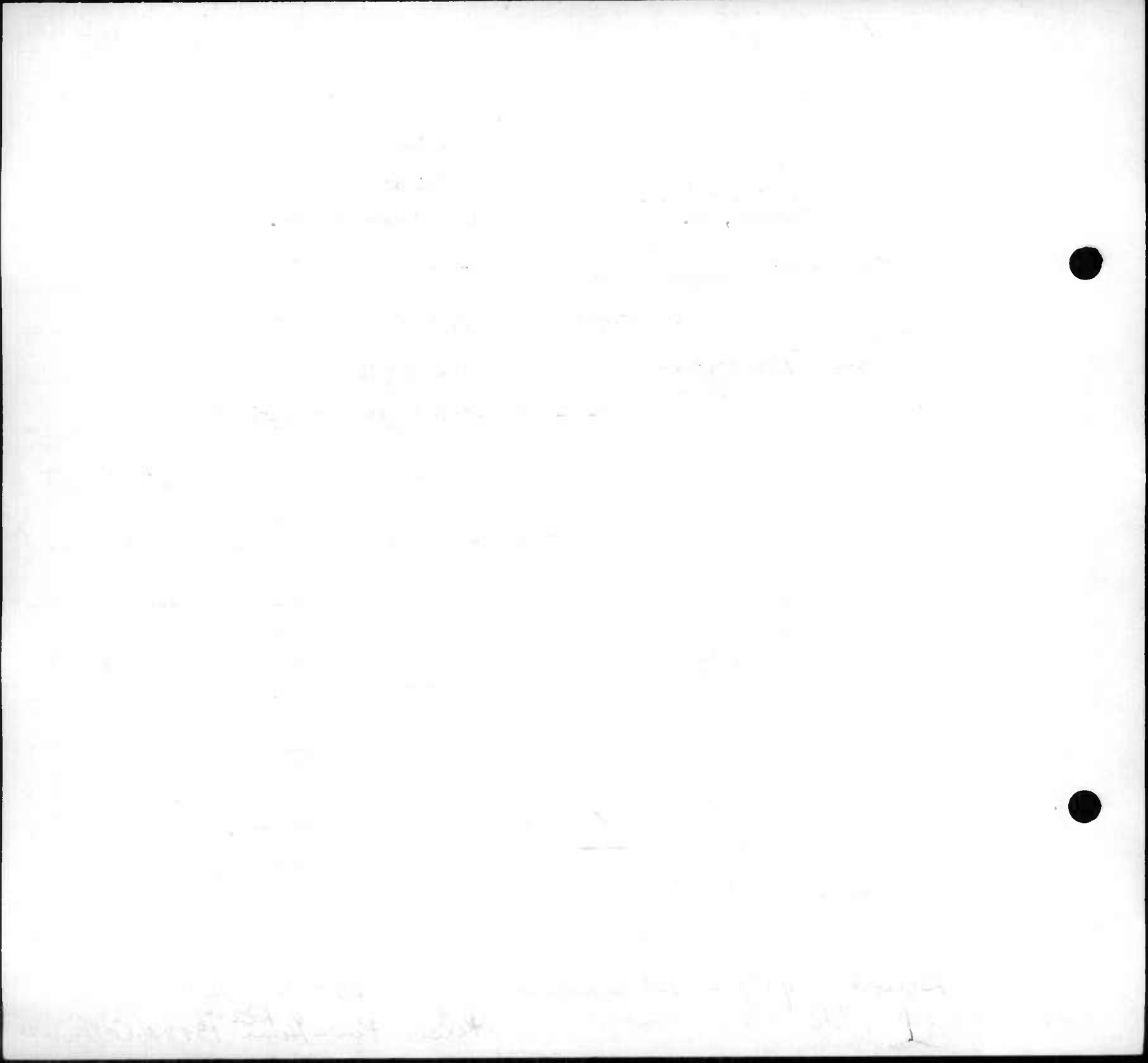
R-351		72 00196		BALTIMORE CITY HEALTH DEPARTMENT		72 00196	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MARY C. ROTHEN BUECHER</b>				2. DATE AND HOUR OF DEATH <b>1-8-72 6:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2607</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>317 NEWKIRK ST. #21224</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 1, 1890</b>	9. AGE in years last birthday <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEPHEN HELFER</b>				14. MOTHER'S MAIDEN NAME <b>LENA SWARTZ</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ADAM G. ROTHENBUECHER</b>		ADDRESS <b>SAME</b>	
18. <b>199.0 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Urinary Tract Infection</b>							
19A. DATE OF OPERATION <b>1-8-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month <input type="checkbox"/> 1 Day <input type="checkbox"/> (Year) <input type="checkbox"/> (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1-3-72</b> to <b>1-8-72</b> that (1) (we) last saw the deceased alive on <b>1-3-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John J. Cain M.D.</b>				23B. DATE SIGNED <b>1-8-1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHN J. CAIN M.D.</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-11-72</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>4450 BELAIR RD. BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Guler 901 S. CONNELLING ST. BALTO., MD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00197</u>	
W-30 U 72 00197				CERTIFICATE OF DEATH	
BIRTH NO. <u>W-30 U</u>		1. NAME OF DECEASED (Type or Print) <u>GOLDIE WADE</u>		2. DATE AND HOUR OF DEATH <u>1/8/72</u> <u>4:10 A. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital</u> <u>2600 Liberty Hgts.</u> <u>Baltimore, Md.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1304</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2849 Woodbrook Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-00</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Maggie</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, if unknown) <u>Ill yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>212-32-2730</u>		17. INFORMANT <u>Goldie Chase (daughter) Dame</u>	
18. <u>403X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) Anterior Arteriosclerosis</u> <u>(C) _____</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Several months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cerebral Arteriosclerosis - Small Strokes</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/10/71</u> 19 to <u>1/8/72</u> 19 that (I) (we) last saw the deceased alive on <u>1/8/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Roland T. Smoot</u>			23B. DATE SIGNED <u>1/9/72</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMOOT</u>			23D. ADDRESS <u>2380 GARRISON BLVD., BALTO., MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/13/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Kelson Funeral Home</u>		25D. ADDRESS <u>1348 N. Calhoun</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00198	
S-300 72 00198				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ELDOISE SCOTT</b>		2. DATE AND HOUR OF DEATH <b>1/8/72 5:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1401</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1420 PARK AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-11</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK - MAID.</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. CAROLINA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Joe Waites</b>		
14. MOTHER'S MAIDEN NAME <b>Isabell Shaw</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>MRS HUGH SCOTT - EMPLOYER</b>		
18. <b>566X 142509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPSIS.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PERIRECTAL, PERINEAL and LEG ABSCESS + CELLULITIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DIABETES MELITUS.</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/25 1972</b> to <b>1/8/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/8 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anne L. Liddy</b>				23B. DATE SIGNED <b>1/8/72.</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/14/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Church</b>	
24D. LOCATION (City, town, or county) (State) <b>Monkton S.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>			
25B. NAME OF REGISTRAR <b>John E. Scott</b>		25C. FUNERAL DIRECTOR <b>V.R. Bailey</b>			
25D. ADDRESS <b>Reuben Funeral Home 1348 Calhoun St.</b>					

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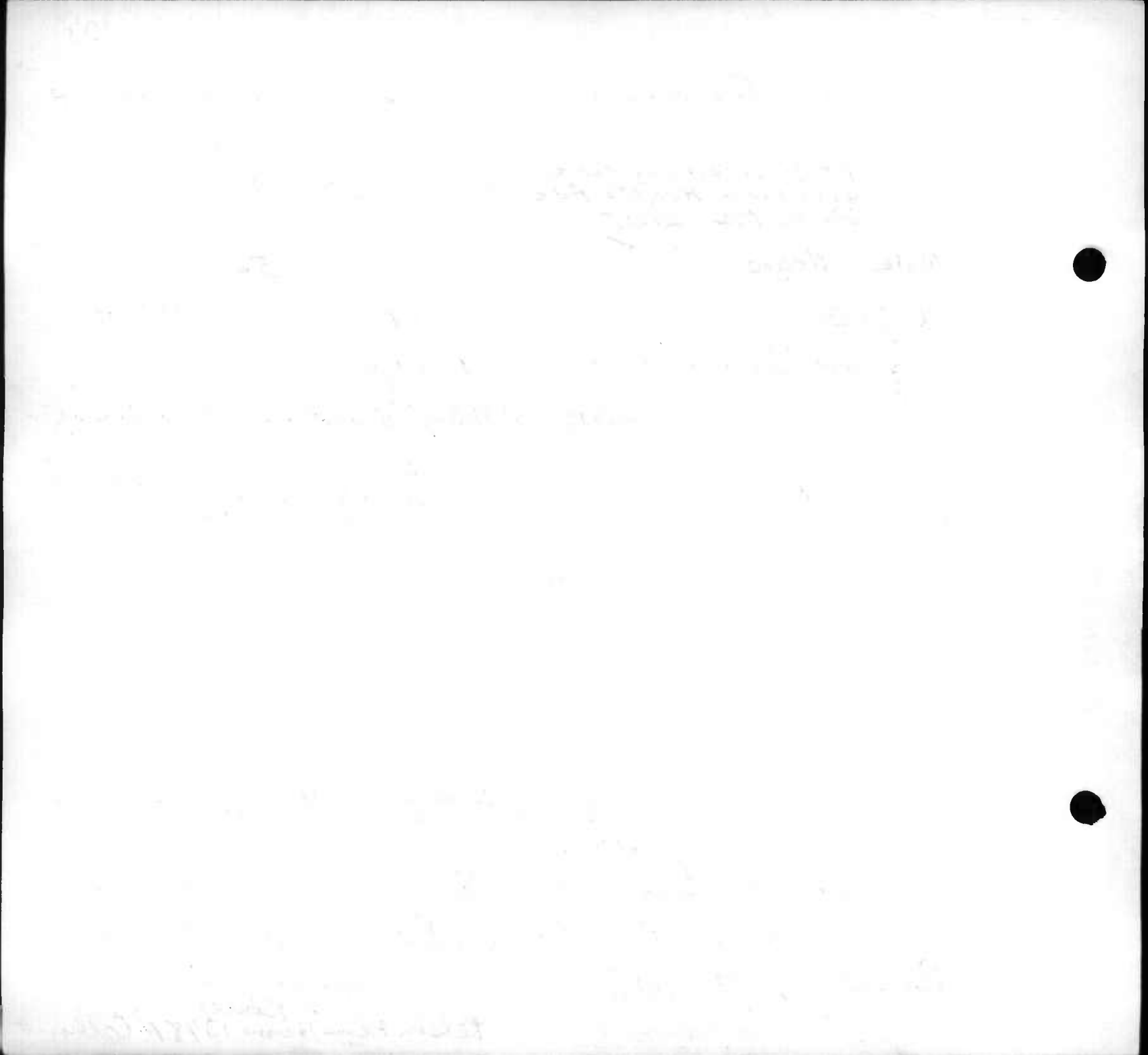
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

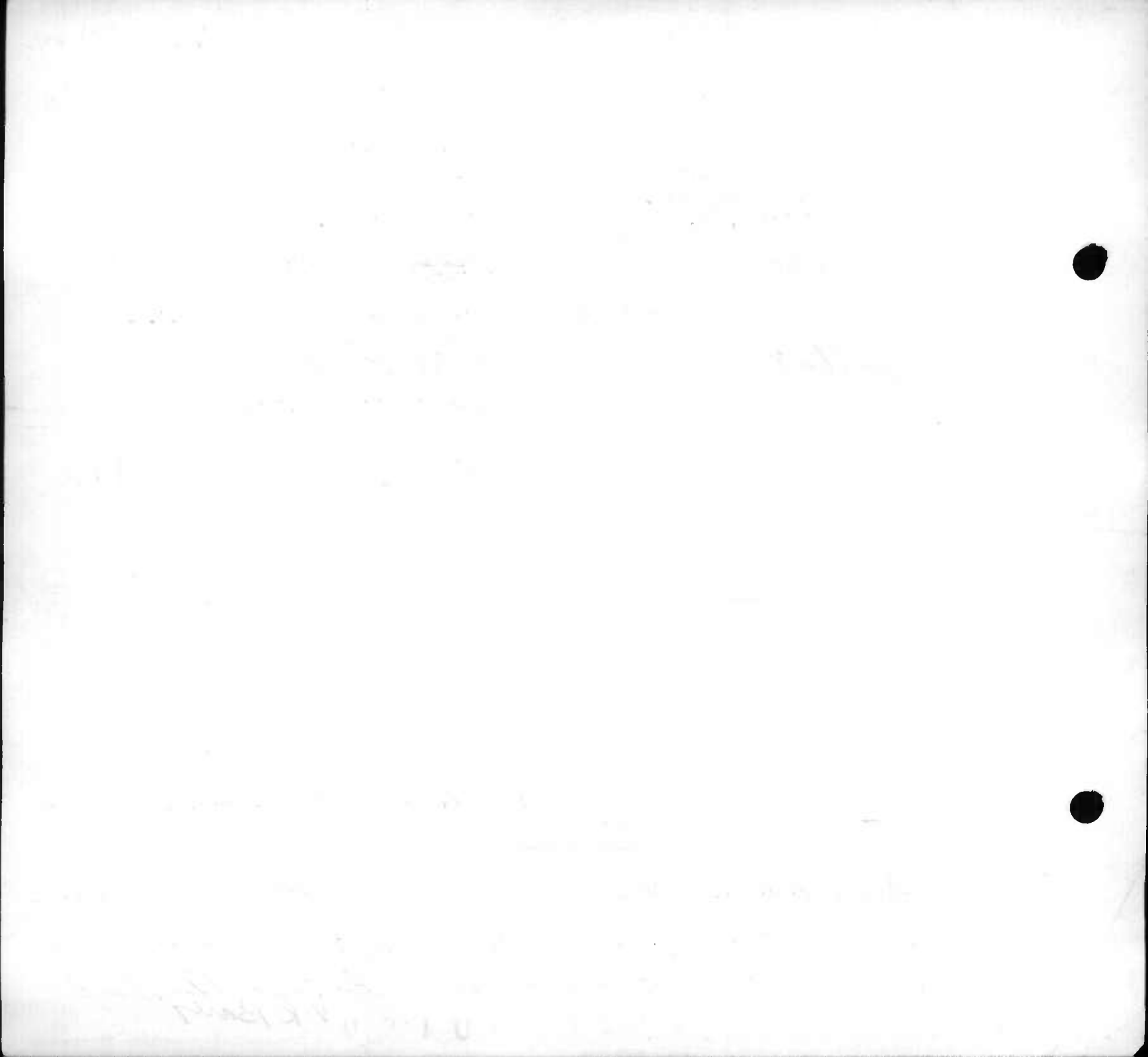
E-355		72 00199		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00199	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Eddie Edmondson</u>				2. DATE AND HOUR OF DEATH <u>January 6 1972</u>   <u>10 10</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Mt Sinai Nursing Home</u> <u>4613 Park Heights Ave</u> <u>Balto Md 21215</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>BALTIMORE MD 21223</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2001</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-15</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RODGER -</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Edmondson</u>			14. MOTHER'S MAIDEN NAME <u>Mary</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>225-14-5493</u>		17. INFORMANT <u>Mary Edmondson</u> ADDRESS <u>1937 W. Lexington</u>		
18. <u>157.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Carcinoma of pancreas</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>metastatic to liver etc.</u>  (B) DUE TO, OR AS A CONSEQUENCE OF: <u>none</u>  (C) <u>none</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White AI <input type="checkbox"/> Not White AI Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 2</u> 19 <u>71</u> to <u>Jan 6</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>Jan 6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Manuel Levin</u> DEGREE <u>MD</u>				23B. DATE SIGNED <u>1/7/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN MD</u> DEGREE <u>MD</u>				23D. ADDRESS <u>101 PARK HIGTS AVE BALTI-MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>Jan 10 1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Burial 1000/00/72 Int. Ashes</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, MD</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>Kelson 72m Home 1348 N. Calhoun</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00200</u>	
<div style="display: flex; justify-content: space-between;"> <span>U-300 72 00200</span> <span>BIRTH NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Elmore White</u>			2. DATE AND HOUR OF DEATH <u>January 7, 1972</u> <u>2<sup>00</sup></u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital</u> <u>2600 Liberty Hgts.</u> <u>Baltimore, Md.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Maryland</u> C. CITY OR TOWN <u>1501</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1543 Leslie St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-3-71</u>	9. AGE (In years last birthday) <u>57</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Flugus White</u>			14. MOTHER'S MAIDEN NAME <u>Esther Brooks</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Isabell Robinson (sister) same</u>		
18. <u>571.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>? 1 yr.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 2, 1972</u> to <u>January 7, 1972</u> that (I) <del>was</del> last saw the deceased alive on <u>January 7, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lewis B. Boone, M.D.</u>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 7, 1972</u>
23C. PHYSICIAN'S NAME (Type) <u>Lewis B. Boone, M.D.</u>			23D. ADDRESS <u>Provident Hospital Baltimore, Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-10-72</u>	24C. NAME of CEMETERY or CREMATORY <u>At. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kalene [unclear] Home</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00201	
CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>M-460</u>		DATE AND HOUR OF DEATH <u>Jan 8, 1972</u> <u>7:40 p.m.</u>			
1. NAME OF DECEASED (Type or Print) <u>Wendell Miller</u>		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital of Md.</u>		A. STATE <u>938 Md.</u>		B. COUNTY <u>Balto.</u> <u>1606</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>938 N. Rosedale St</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-09</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Isaac John Miller</u>		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>250-4-6322</u>		17. INFORMANT <u>Jamil Miller</u> ADDRESS _____	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u> <u>myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> <u>8 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D.S. Karbhari</u>		23B. DATE SIGNED _____		23C. PHYSICIAN'S NAME (Type) <u>D.S. KARBHARI M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE _____		24C. NAME OF CEMETERY or CREMATORY <u>Darlington</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>Rehman Funeral Home 1348 Calhoun St.</u>	

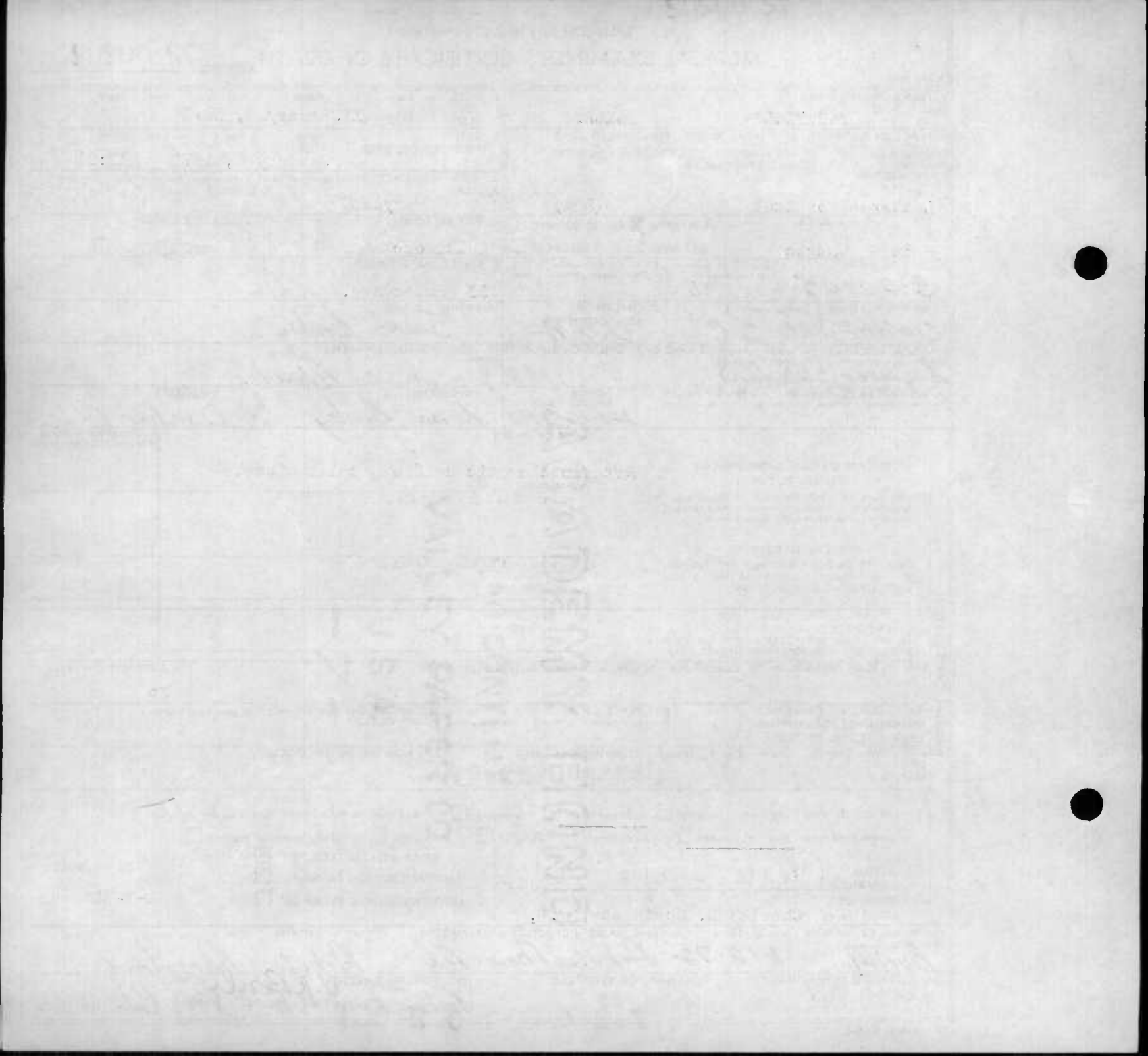
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BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00202

BIRTH NO. <u>B-400</u>		1. NAME OF DECEASED (Type or Print) <b>FAIRFIELD BAILEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>January 8, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 8, 1972</b>		Hour <b>12:31 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>3-20-05</b>		10. AGE (In years last birthday) <b>66</b>		11. BIRTHPLACE (State or foreign country) <b>Smithfield S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Bailey</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer (Stationary)</b>	
15. MOTHER'S MAIDEN NAME <b>Josephine Newby</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>230-09-9751</b>	
18. INFORMANT <b>Lenn Bailey</b>		ADDRESS <b>33 Dunbar Ave.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>412.4</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-8-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>James S. Bailey</b>	
25C. FUNERAL DIRECTOR <b>Kelley Funeral Home</b>		ADDRESS <b>1348 Calhoun St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 00203		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
LOUISE YOUNG				1/1/72 1630 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. HOSPITAL 38				A. STATE MD		B. COUNTY 1605			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 2429 W. LAFAYETTE AVE					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-3-99	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALTER KENT				14. MOTHER'S MAIDEN NAME VICTORIA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. -		17. INFORMANT TROPHEA JOHNSON 2429 W. LAFAYETTE AVE 21216			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 CAUSE OF DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC RENAL FAILURE 10 yrs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE ? DUE TO, OR AS A CONSEQUENCE OF:					
				(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				ACUTE & CHRONIC BLOOD LOSS				1-2 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Kenneth V. Eden M.D.				23B. DATE SIGNED 1/1/72					
23C. PHYSICIAN'S NAME (Type) KENNETH V. EDEN MD				23D. ADDRESS UNIV. HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-72		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR John E. Bailey, M.D.		25C. FUNERAL DIRECTOR J. R. Bailey		ADDRESS 1348 N. Calhoun St.			

8-3-88

15

16

BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HENRY CORBIN</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>January 5, 1972</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 5, 1972 11:40 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1605</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>5-26-34</b>		10. AGE (In years last birthday) <b>37</b>		E. STREET AND NUMBER <b>2337 Edmondson Avenue</b>			
11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Wm. Hawkins</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>HATTIE</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>HATTIE MILLS 2541 GRATZ ST.</b>			
MEDICAL CERTIFICATION 19. <b>E 965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <b>Gunshot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>1500 blk Pennsylvania Avenue 1402</b>			
22D. TIME OF INJURY (APPROX.) <b>1-5-72 11:20 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>January 6, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-10-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Rolland Green</b>		24D. LOCATION (City, town, or county) (State) <b>West Chester Co., Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>N 854.1</b>		25C. FUNERAL DIRECTOR, BAITER ADDRESS <b>Kelson F. N. 1348 Calhoun St.</b>			

2-26-34  
M.D.

U.S. A. Wm. Hawkins

Hattie

Hattie Mice 4811 Cent St

Quinn 1-10-34  
Kahn F.H. 1886 Collier St  
Kahn F.H. 1886 Collier St



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

REG. NO. 72 00205

1-525 72 00205

BIRTH NO. 1-525

1. NAME OF DECEASED (Type or Print) Johnson, Kennard 2. DATE AND HOUR OF DEATH 1/6/72 8:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Montebello State Hospital 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
 A. STATE Md. B. COUNTY 2717

5. SEX Male 6. RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 1-7-12 9. AGE (in years last birthday) 59 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor Driver 10B. KIND OF BUSINESS OR INDUSTRY Penna. Rail Road 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jessie Johnson 14. MOTHER'S MAIDEN NAME Sarah Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No 16. SOCIAL SECURITY NO. Patient's Chart 17. INFORMANT Bernice Dent ADDRESS Same

18. 1/6/72 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardio-respiratory failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
 ANTECEDENT CAUSES Post laryngectomy Cachexia 12 months  
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma Larynx since 1970

II  
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO. 20A. AUTOPSY? (Yes or No) NO. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Indicate medical examined) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 5 1972 to January 6 1972 that (I) (we) last saw the deceased alive on 6:00pm January 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Hanson Chen 23B. DATE SIGNED January 6, 1972  
 Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23C. PHYSICIAN'S NAME (Type) HANSON S.H. CHEN, M.D. 23D. ADDRESS Montebello State Hospital, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/10/72 24C. NAME OF CEMETERY OR CREMATORY mt. Auburn Cem. 24D. LOCATION (City, town, or county) (State) Balto., Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972 25B. NAME OF REGISTRAR Robert J. ... 25C. FUNERAL DIRECTOR O. Butler ADDRESS 1348 N. Calhoun St.

VS 150-REV. 1/1/68

Jessie Johnson

James Brown  
George Davis  
John

Paula  
1/10/12  
Mrs. Johnson  
Baltimore, Md.  
C. Carter  
1912  
John A. Johnson



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0-625

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>SUSAN ORSINI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 9 1972 3:15p</b> M.	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Washington, D.C.</b>	
9. DATE OF BIRTH <b>3/24/50</b>		10. AGE (In years last birthday) <b>21</b>	
11. BIRTHPLACE (State or foreign country) <b>Phila. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Anthony Orsini</b>		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Viola Ezzo</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>DONE</b>	
18. INFORMANT <b>Mr. A. Orsini, 5257 American St.</b>		ADDRESS	
19. <b>E 812.1</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple injuries</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>I 95 so. 1 1/2 mi. s. of Aberdeen, Md.</b>		22D. TIME OF INJURY (APPROX.) <b>12-25-71 6:10 p.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto accident.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>1-10-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Sepulchre Cem. Wyndmoor, Mt. Co. Pa.</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>George J. Schuster</b>		ADDRESS <b>2101 Frederick Ave</b>	

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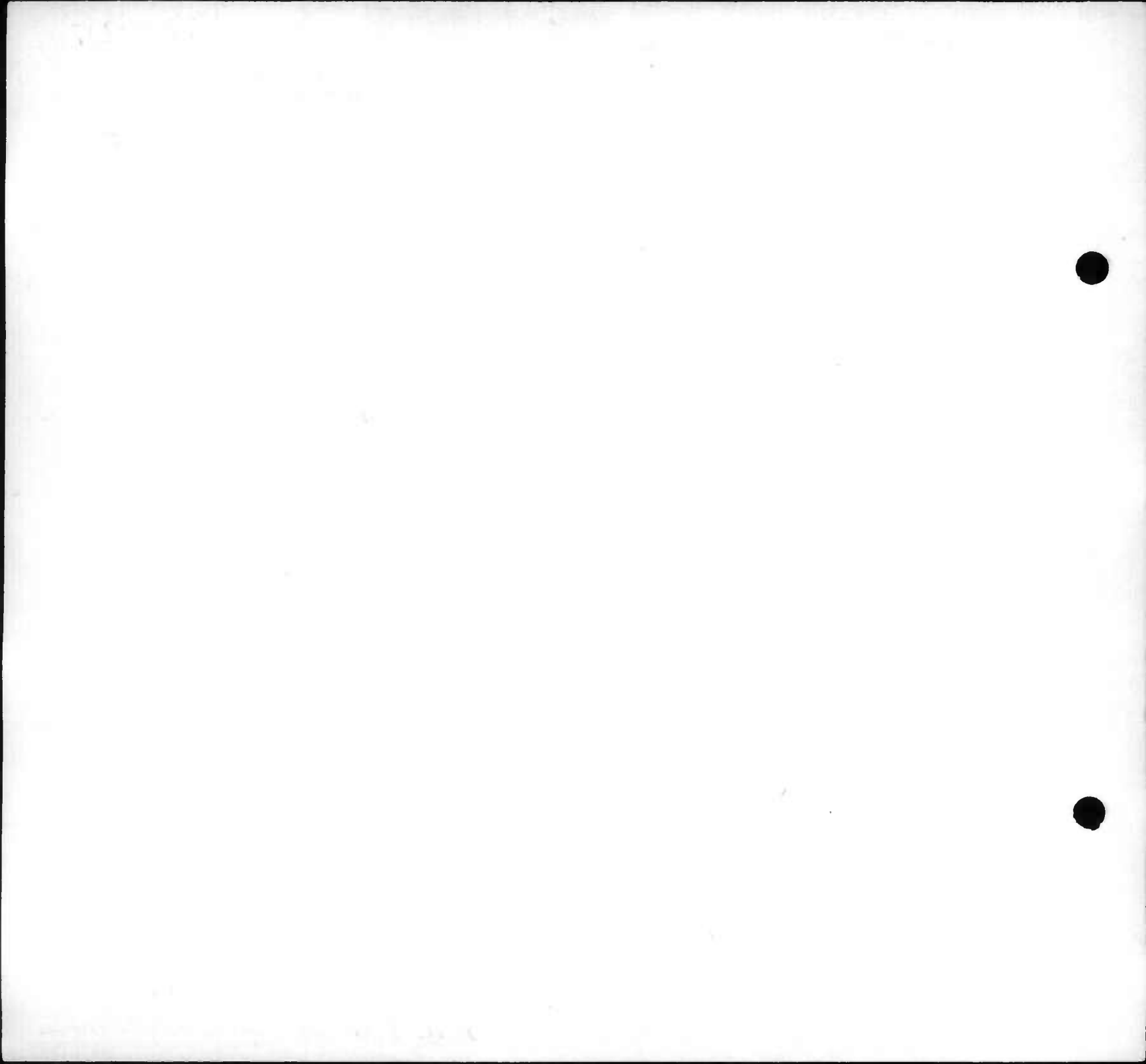
10/10/50

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00207	
U-252 72 00207 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WASHINGTON, ERNESTINE		2. DATE AND HOUR OF DEATH 1/7/72 at 6:20 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Md.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1604 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2023 Harlem Ave - 21217		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-26	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME STERNHART HILL			14. MOTHER'S MAIDEN NAME MARY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS David Washington 2023 Harlem Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebro-Vascular Accident (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/6/1972 to 1/7/1972 that (I) (we) last saw the deceased alive on 1/7/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anjana Joshi M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ANJANA JOSHI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-13-72		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem	
24D. LOCATION (City, town, or county) (State) Ann Arundel City, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR ROBERT J. JOHNSON, M.D.	
25C. FUNERAL DIRECTOR ADDRESS OYAKO MARCIA 928 E North Ave					

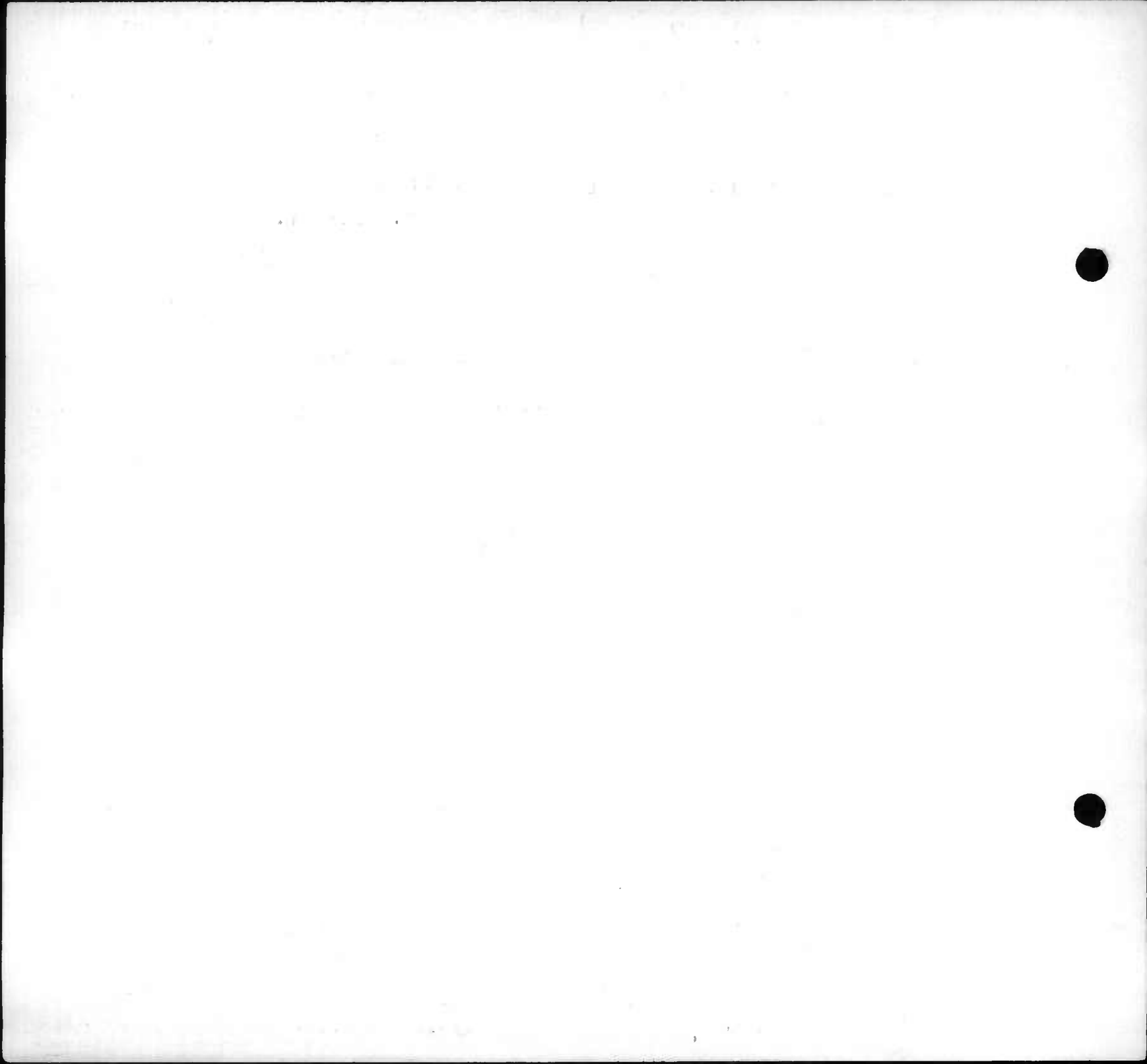


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baptist

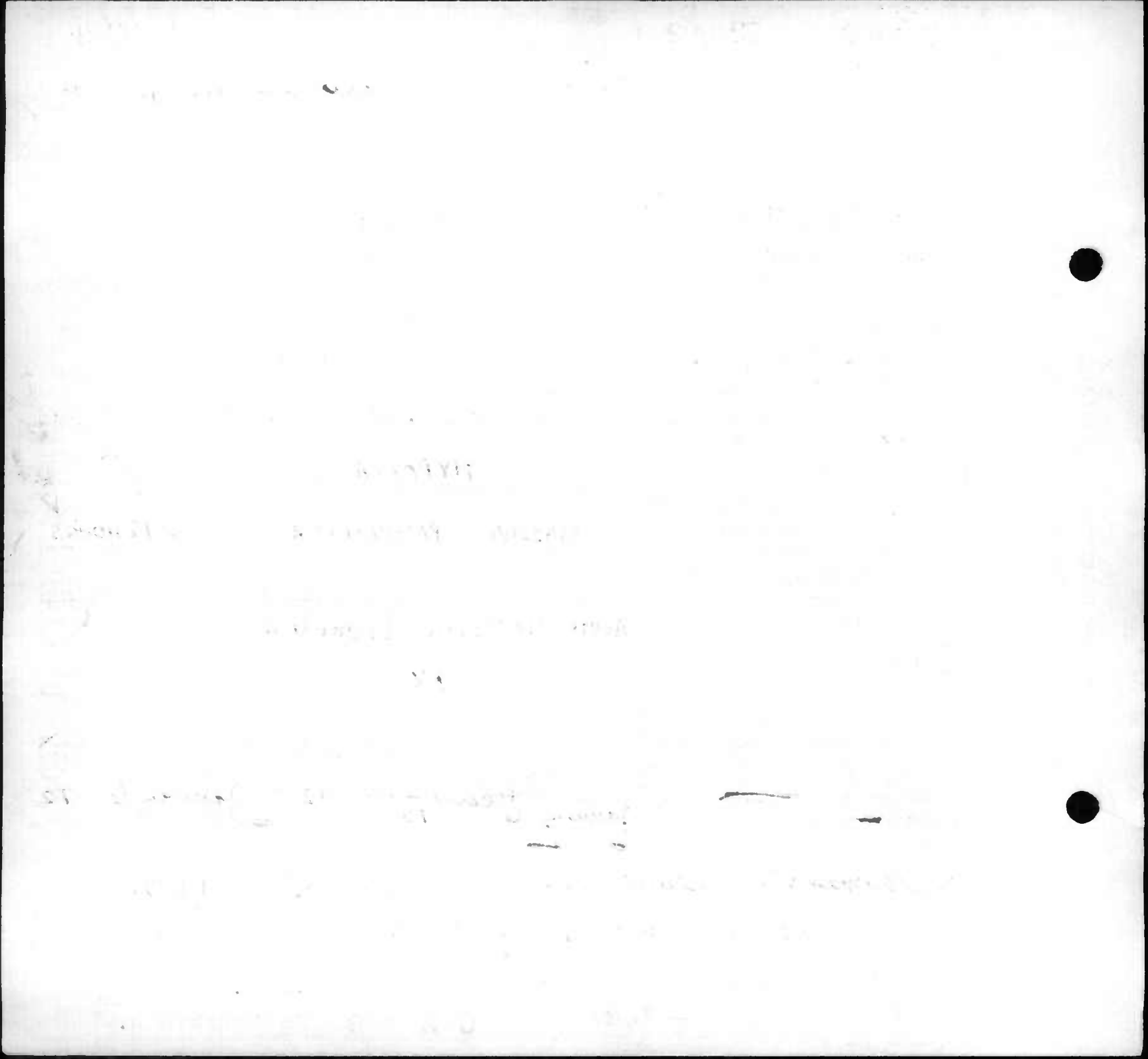
BIRTH NO. <u>M-460</u> <u>72 00208</u> <u>A.</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00208</u>	
1. NAME OF DECEASED (Type or Print) <u>JAMES MILLER</u>				2. DATE AND HOUR OF DEATH <u>1-4-72</u> <u>16:35 P</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>1001</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1201 N. EDEN ST.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/04/18</u>		9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silver Syrup Tapper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Soda Fountain Syrup</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina (Durham)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Miller</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown) Agnes Brown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>243-18-80-73</u>		17. INFORMANT <u>Fannie Hedgepeth</u>		ADDRESS <u>Durham N.C.</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIO-PUL event</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
				(B) <u>CATAstrophic CNS event of undeter-</u> DUE TO, OR AS A CONSEQUENCE OF: <u>mined etio?</u>		<u>20 hours</u>	
				(C) <u>Hypertension</u>		<u>sev. years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-3-72</u> 19__ to <u>1-4-72</u> 19__ that (I) (we) last saw the deceased alive on <u>1-4-72</u> 19__ and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Horan MD</u>				23B. DATE SIGNED <u>1-4-72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. HORAN MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-8-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MA. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. [illegible]</u>		25C. FUNERAL DIRECTOR <u>WYMC</u>		ADDRESS <u>928 E. 11th Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>R-162</u> <u>69-23378</u>		BALTIMORE CITY HEALTH DEPARTMENT 72 00209 CERTIFICATE OF DEATH		REG. NO. <u>72 00209</u>
1. NAME OF DECEASED (Type or Print) <u>RIVERS, Glenn Jr.</u>		2. DATE AND HOUR OF DEATH <u>January 6, 1972</u> <u>1:20 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33</u> <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2739</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1332 Kitmore Road</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/04/69</u>	9. AGE (in years last birthday) <u>2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Glenn K. Rivers, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Louise Franklin</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Glen K. Rivers Sr.</u>
				ADDRESS <u>1332 Kitmore Rd.</u>
18. <u>486X 19 206.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>HYPOXIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MASSIVE PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ACUTE MONOCYTIC LEUKEMIA</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) <del>(this hospital)</del> attended the deceased from <u>December 25</u> 19 <u>72</u> to <u>January 6</u> 19 <u>72</u> that (1) <del>(he)</del> last saw the deceased alive on <u>January 6</u> 19 <u>72</u> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>(he)</del> (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <u>Thomas G. Quattlebaum</u>		23B. DATE SIGNED <u>1/6/72</u>		23C. ADDRESS <u>The Johns Hopkins Hospital</u>
23D. PHYSICIAN'S NAME (Type)				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
<u>Burial</u>		<u>1-11-72</u>		<u>Mt Auburn Cemetery</u>
24D. LOCATION (City, town, or county) (State)		<u>Balto., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
<u>JAN 10 1972</u>		<u>Robert E. Taylor, M.D.</u>		<u>Om P. March</u>
				ADDRESS <u>928 E North Ave.</u>





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-660</b>      72 00210      BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>72 00210</p> <p>REG. NO. _____</p>	
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>CLARENCE GRIER</b></p>		<p>2. DATE AND HOUR OF DEATH <b>5 JANUARY 1972 10:50 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1703</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1007 ARGYLE AVE.</b></p>	
<p>5. SEX <b>MALE</b></p>	<p>6. RACE <b>NEGRO</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>4-18-14</b></p>
<p>9. AGE (In years last birthday) <b>57</b></p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOILER CLEANER</b></p>
<p>10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b></p>	<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>
<p>13. FATHER'S NAME _____</p>		<p>14. MOTHER'S MAIDEN NAME _____</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b></p>		<p>16. SOCIAL SECURITY NO. <b>579-05-1334</b></p>	<p>17. INFORMANT <b>MABEL GRIER WIFE</b> ADDRESS <b>1007 ARGYLE AVE BALTIMORE, MD.</b></p>
<p>18. <b>41320 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			
<p>(A) IMMEDIATE CAUSE <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b></p>	
<p>(B) <b>ACUTE TUBULAR NECROSIS</b> DUE TO, OR AS A CONSEQUENCE OF:</p>		<p><b>2 WEEKS</b></p>	
<p>(C) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b></p>		<p><b>@ 15 YRS</b></p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>INFARCTUM RIGHT CEREBRUM</b></p>			
<p>19A. DATE OF OPERATION <b>2</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>YES</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (the <del>hospital</del>) attended the deceased from <b>13 DECEMBER 1971</b> to <b>5 JANUARY 1972</b> that (I) (we) last saw the deceased alive on <b>5 JANUARY 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Harry A. Spalt</b> MD DEGREE</p>		<p>23B. DATE SIGNED <b>5 January 1972</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>HARRY A. SPALT</b></p>		<p>23D. ADDRESS <b>MARYLAND GENERAL HOSP, BALTIMORE, MD.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>1-10-71</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mempk.</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Balto, Md</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>E. Taylor, R.D.</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Alfred Ford &amp; Dyett F. H.</b></p>		<p>ADDRESS <b>1701 - Lawrence St</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00211	
G-612 72 00211				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Graves, Nellie		January 5, 1972 7:45 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 2600 Liberty Hgts. Baltimore, Md.		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Unemployed		8. DATE OF BIRTH 6-1-99	
				9. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		11 Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
North Carolina		USA			
13. FATHER'S NAME Silis Graves			14. MOTHER'S MAIDEN NAME Lizzie Moorehead		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-10-6516		
17. INFORMANT Beverly Banke (daughter)			ADDRESS same 466-3831		
18. 4 32.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pontine Haemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: Basilar artery thrombosis (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HCV					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 3 19 72 to January 5 19 72, that (I) (we) lost saw the deceased alive on January 5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Shafi				23B. DATE SIGNED 1-7-72	
23C. PHYSICIAN'S NAME (Type) MUHAMMAD JAVAD SHAFI				23D. ADDRESS PROVIDENT HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-12-72		24C. NAME OF CEMETERY or CREMATORY Maplewood Cemetery	
				24D. LOCATION (City, town, or county) (State) Greensboro, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR D. J. Shafi		25C. FUNERAL DIRECTOR Monton & Dyett F. H. 1701 Laurens St.	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00212

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William E. WILLIE WILLIAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year January 5, 1972		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 5, 1972		Hour 5:55 P.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-25-23		10. AGE (In years last birthday) 48	11. BIRTHPLACE (State or foreign country) Windsor, North Carolina	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME James E. Williams		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME Jane Douglas		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219-16-2654
18. INFORMANT Mr. Frank Williams		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver with cirrhosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21. AUTOPSY? (Yes or No) Yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
24. TIME OF INJURY (APPROX.) 22D. TIME (Month) (Day) (Year) (Hour)		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		29. DATE SIGNED January 6, 1972
30. ACTUAL SIGNATURE Charles S. Springate, M.D.		31. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		32. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
33. NAME (Type) Charles S. Springate, M.D.		34. DATE 1-10-72		35. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery
36. LOCATION (City, town, or county) Baltimore, Maryland		37. DATE REC'D BY HEALTH DEPT. JAN 10 1972		38. NAME OF REGISTRAR Robert E. Taylor, M.D.
39. FUNERAL DIRECTOR Morton & Dyett F. H.		40. ADDRESS 1701 Laurens St.		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00213</u>	
BIRTH NO. <u>B-63</u> <u>72 00213</u>		1. NAME OF DECEASED (Type or Print) <u>BOARDLEY GERIRUDE</u>			
2. DATE AND HOUR OF DEATH <u>1/6/1972 at 4:15 AM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u> <u>730 Ashburton Street - Baltimore, Md. 21216</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21216</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/1900</u>		9. AGE (In years last birthday) <u>71 yrs.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Obie Hayes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Naomi Parker - 8224 - Arrowhead Rd</u>	
18. <u>207-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute respiratory infection.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Malnutrition</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>2 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>12/4/1971</u> 19 to <u>1/6/1972</u> 19 that (I) (we) last saw the deceased alive on <u>1/6/1972</u> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>1/6/1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. SURESH PENKAR</u>	
23D. ADDRESS <u>Lutheran Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1-10-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Garden of Eternal Hope</u>		24D. LOCATION (City, town, or county) (State) <u>Finksbury, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
25D. ADDRESS <u>[Signature]</u>					



The House

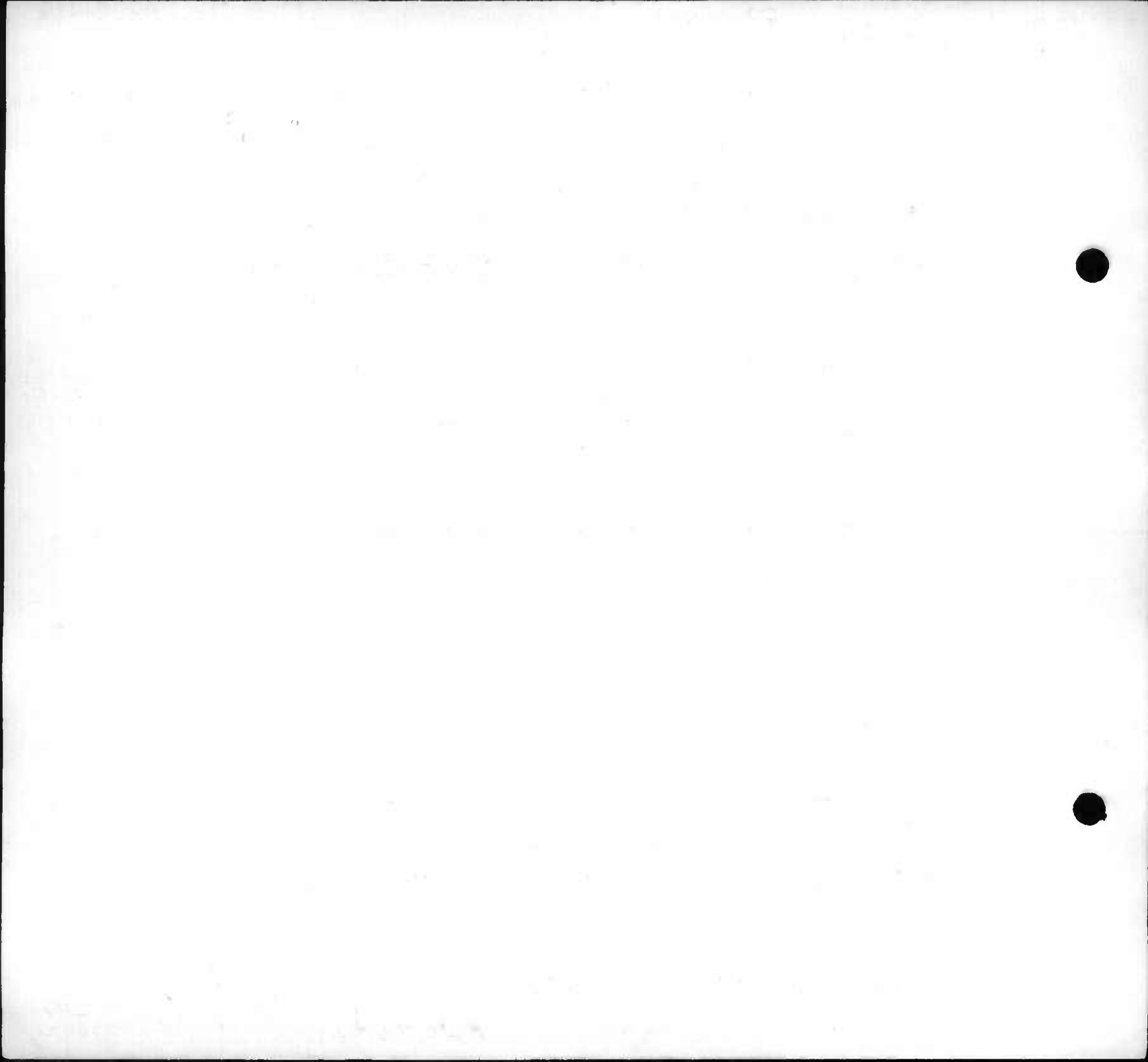
Self and  
other things  
from the

House of Representatives  
March 1874



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-652 72 00214		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>7</u>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LAURA FRANKLIN</u>		2. DATE AND HOUR OF DEATH <u>1-4-72</u> <u>4:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL, BALTIMORE, MD.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>520 ANNE ARUNDEL</u>			
				C. CITY OR TOWN <u>GLEN BURNIE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>Rte. 1, Box 330, Glen Burnie, Md.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-1901</u>	9. AGE (in years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>LUCINDA CLARK</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-2314</u>		17. INFORMANT <u>Almeda Anderson</u>		ADDRESS <u>2429 Keyworth Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>182.01</u> CAUSE OF DEATH <u>RECURRENT ENDOMETRIAL CARCINOMA</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ADENOCARCINOMA OF ENDOMETRIUM</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DISSEMINATED INTRAVASC. COAGULATION 3 DAYS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 YR.</u> <u>1 YR.</u>							
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DISSEMINATED INTRAVASC. COAGULATION 3 DAYS</u>							
19A. DATE OF OPERATION <u>6-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ADENOCARCINOMA OF ENDOMETRIUM</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? <u>-</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(4)</u> (this hospital) attended the deceased from <u>12-29-1971</u> to <u>1-4-1972</u> that <u>(4)</u> (we) last saw the deceased alive on <u>1-4-1972</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(4)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Nathaniel Aikins-Afful, M.D.</u>				23B. DATE SIGNED <u>1-4-72</u>		23C. PHYSICIAN'S NAME (Type) <u>NATHANIEL AIKINS-AFFUL, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1-8-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	
24D. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>				24E. FUNERAL DIRECTOR <u>Robert J. Dyett</u>		24F. ADDRESS <u>St. F.H. 1901-Harveys</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>				25B. NAME OF REGISTRAR <u>Robert J. Dyett</u>		25C. FUNERAL DIRECTOR <u>Robert J. Dyett</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MATTIE STROTHER (STRODER)

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

January 6, 1972

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3006 W. North Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 6, 1972

12:15 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

1506

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2-13-22

10. AGE (In years  
last birthday)

49

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3006 W. North Avenue

11. BIRTHPLACE (State or foreign country)

Greenwood, S. C.

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

James Butler

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Katie Robinson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Minnie Oliver-2914 Clifton Avenue

19.

34519

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Epilepsy  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

ii

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
m. WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Charles S. Springate  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 6, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-10-72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 10 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Morton &amp; Dyett F. H. 1701 Laurens St.

MEMORANDUM FOR THE RECORD

DATE: 10/1/54

TO: Mr. Tolson

FROM: Mr. Clegg

RE: [illegible]

[illegible]

[illegible]

[illegible]

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SIMON COOPER JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 5, 1972</b>		Hour <b>3:50 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 5, 1972</b>		Hour <b>3:50 P.M.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1512</b>				
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>2-11-48</b>		10. AGE (in years last birthday) <b>23</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF <b>WHAT COUNTRY?</b>		13. FATHER'S NAME <b>Simon Cooper, Sr.</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Mrs. Ellen Milton 3508 Cottage Avenue</b>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-50-2312</b>		18. INFORMANT ADDRESS <b>Mrs. Ellen Cooper 3508 Cottage Avenue</b>
19. CAUSE OF DEATH <b>E-9651X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>28 2600 block Quanco Avenue 1513</b>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>		
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>12-25-71 1:15 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 6, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-8-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		
25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>		

1957

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W. J. ...

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

TENAGLIA, FRANK

2. DATE AND HOUR OF DEATH

1-8-72

5:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

THE UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND - BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4020 BIDDISON LANE, 21206

5. SEX

M

6. RACE

W.

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9-19-97

9. AGE (In years last birthday)

74

If Under 1 Yr.

Months

If Under 24 Hrs.

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

Pipe layer

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SYLVESTER TENAGLIA

14. MOTHER'S MAIDEN NAME

ZAPPA MARIA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-01-6895A

17. INFORMANT

ADDRESS

Maria D. Tenaglia 4020 Biddison Lane 21206

18.

011191

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

SUPERIMPOSED INFECTION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

BRONCHOPNEUMONIA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

COLD - TB? Desnutrition

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-27 1971 to 1-8 1972 that (I) (we) last saw the deceased alive on 1-8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Julio A. Dejo*

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-8-72

23C. PHYSICIAN'S NAME (Type)

JULIO A. DEJO M.D.

DEGREE

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

burial

24B. DATE

Jan. 11, 72

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cem.

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D. BY HEALTH DEPT.

JAN 10 1972

25B. NAME OF REGISTRAR

*E. Taylor*

25C. FUNERAL DIRECTOR

Doppel Bro's Inc 7110 Belair Rd 21206

ADDRESS

A2.0

A2.0-1.1





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00218</u>	
<u>11-425</u> BIRTH NO.				72 00218			
1. NAME OF DECEASED (Type or Print) <u>Thomas Norton Wilson</u>				2. DATE AND HOUR OF DEATH <u>January 6, 1972</u> <u>850 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital DOA</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2734</u>			
5. SEX <u>male</u>				6. RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Oct. 16, 1907</u>				9. AGE (in years last birthday) <u>64</u>		10. Under 1 Yr. Months: Days:    11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Vice Pres.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Union Trust Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry T. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Ruckle</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-14-1729</u>		17. INFORMANT <u>Elmyra Wilson</u>	
18. <u>410.014-230.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary arteriosclerosis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> <u>Previous myocardial infarctions</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary arteriosclerosis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>10 years +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus</u> <u>Hypertensive Cardiovascular disease</u>				19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Diabetes</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>62</u> to <u>January</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 7</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Richard N. Tillman, MD</u>				23B. DATE SIGNED <u>Jan 7, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard Nelson Tillman M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Jan 10, 72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>Dope Brothers Inc.</u>			
ADDRESS <u>7110 Belair Rd. 21206</u>							

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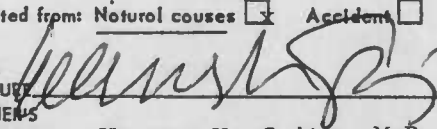
M 324

72 00219

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00219

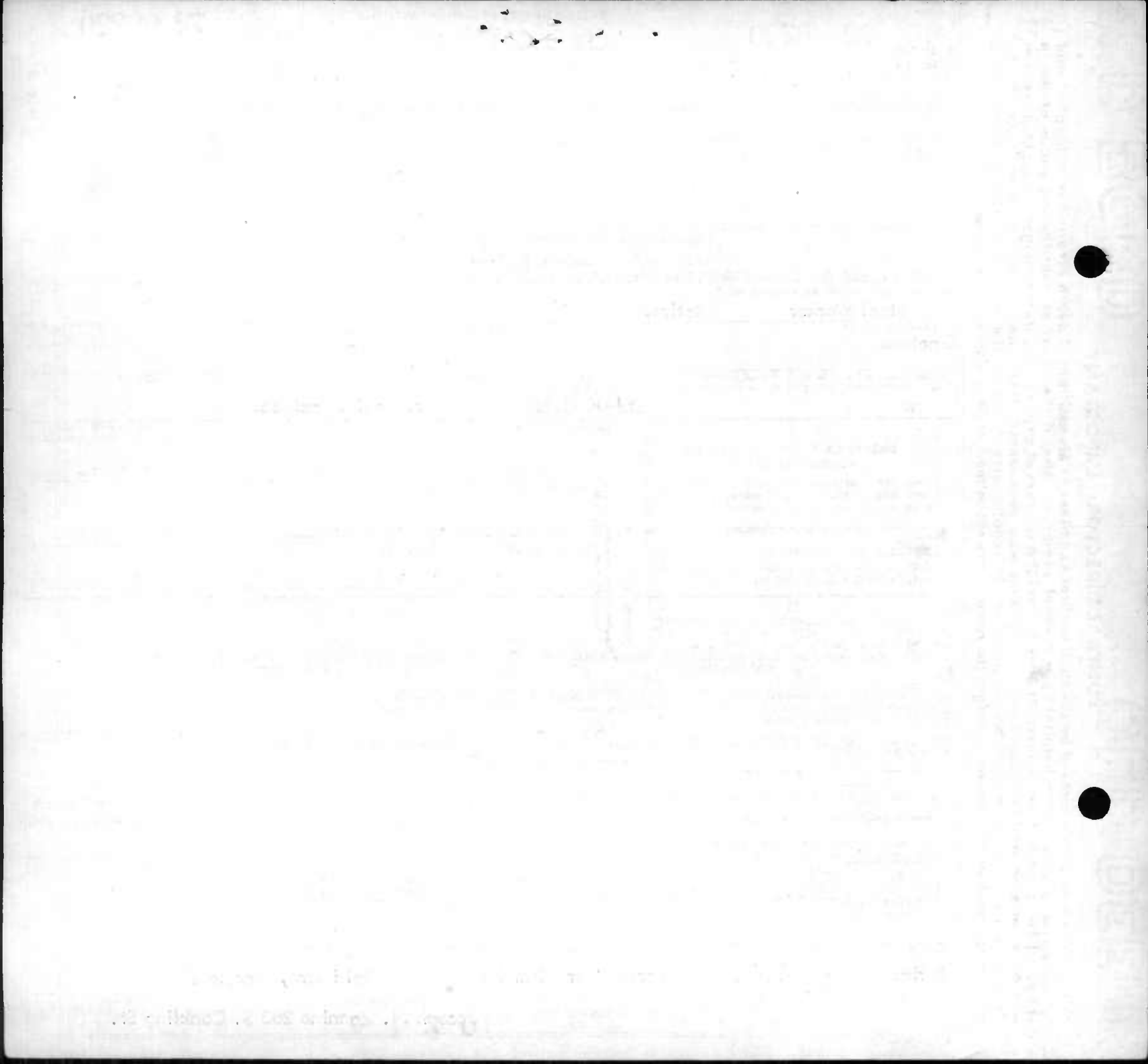
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joseph Mitchell		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 4 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3515 Claremount Street		3. DATE PRONOUNCED DEAD Month 1 Day 4 Year 72 Hour M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2608	
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-22-1995		10. AGE (In years last birthday) 76	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Michael Matuszak		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - shipfitter		15. MOTHER'S MAIDEN NAME Michaelena Krytkouska	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-10-3102		18. INFORMANT ADDRESS Mrs. Aretta Bisignani, 3515 Claremount St.	
19. 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma of prostate with metastasis DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE:  Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-6-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-7-72		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Joseph N. Zannino		25D. ADDRESS 263 S. Conkling Street	



# FUNERAL DIRECTOR: IMPORTANT

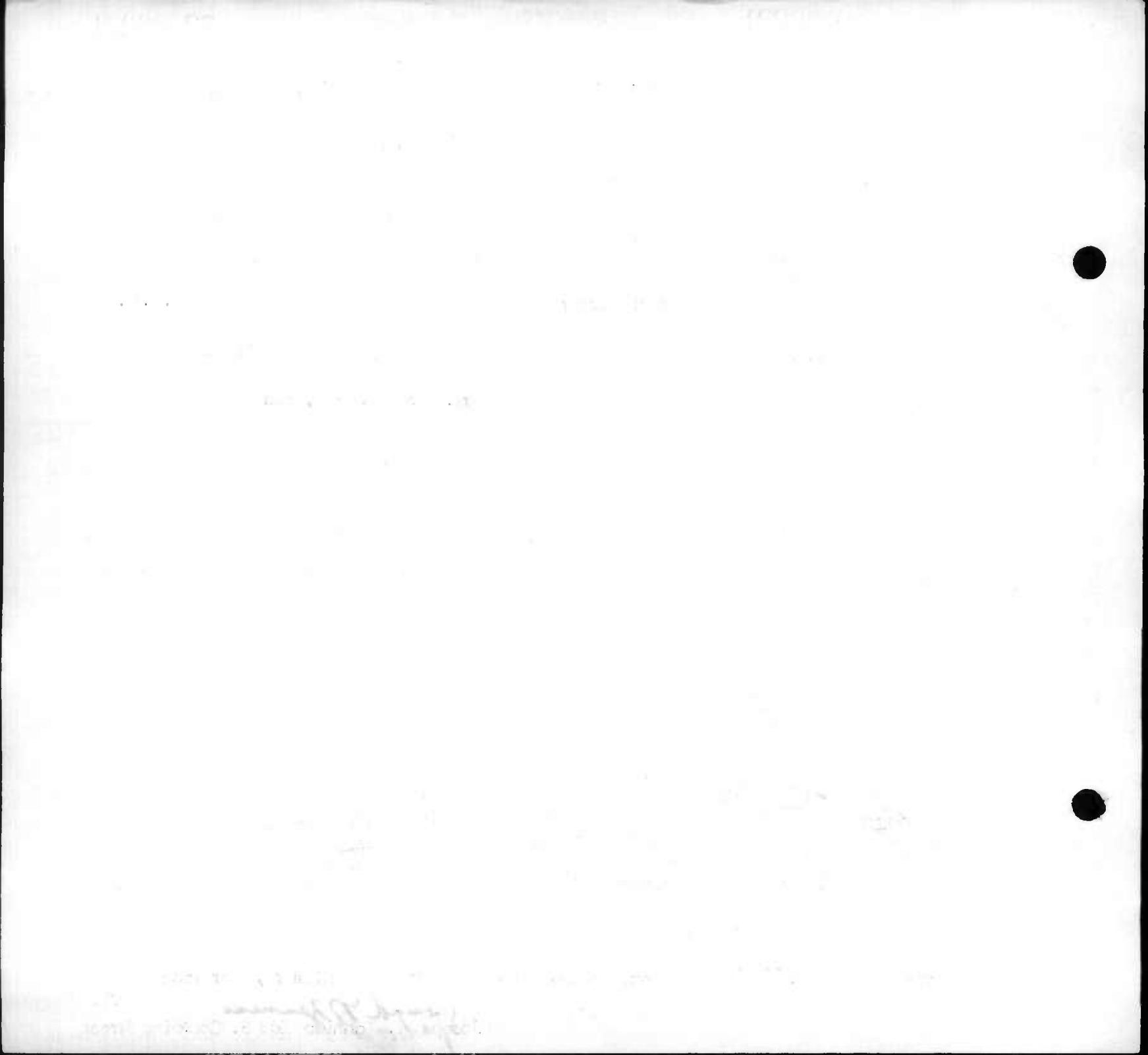
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00220</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>72 00220</u>		1. NAME OF DECEASED (Type or Print) <u>Paciocco, William</u>		2. DATE AND HOUR OF DEATH <u>1/9/72</u> <u>4:30 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <u>Mercy Hospital</u> <u>301 St. Paul Place</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2608</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3916 Claremont St.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/98</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gaetano Gus Paciocco</u>		14. MOTHER'S MAIDEN NAME <u>Da Philomena Stenta</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>413-09-3685</u>		17. INFORMANT <u>Mr. Daniel Paciocco</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>E9491</u> <u>HEPATIC FAILURE</u>		IMMEDIATE CAUSE <u>Hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Post-necrotic liver disease</u> <u>Halothane hepatitis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 Weeks</u> <u>3 Months</u> <u>1 Year</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>3-22-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hernia Repair</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>401</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Mercy Hosp - 301 St. Paul Place</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>3-28-68</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Reaction to Halothane Anesthesia</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>71</u> to <u>1/9</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>1/9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John J. ONE</u>				23B. DATE SIGNED <u>1/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>John J. ONE</u>				23D. ADDRESS <u>Mercy Hospital, Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/12/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Sacred Heart Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Joseph N. Zannino</u>		25C. FUNERAL DIRECTOR <u>Joseph N. Zannino</u>	
ADDRESS <u>263 S. Conkling St.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 00221		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00221	
1. NAME OF DECEASED (Type or Print) <b>WEIDO DI MAIO</b>			2. DATE AND HOUR OF DEATH <b>JAN. 6, 1972</b> <b>5:40A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>CHURCH HOME AND HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY <b>2608</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>119 S. HIGHLAND AVENUE</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-20-1911</b>		9. AGE (In years last birthday) <b>60</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Worker</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
13. FATHER'S NAME <b>MARKO DI MAIO</b>			14. MOTHER'S MAIDEN NAME <b>THERESA ? Rivoli</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-3562</b>		17. INFORMANT <b>Mrs. Sarah DiMaio, same</b>	
18. <b>410.9+1-23-0.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ONE HOUR</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>4 days.</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS</b>			<b>6 YRS.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>1. 4. 1972</b> to <b>1. 6. 1972</b> that <b>(W)</b> (we) last saw the deceased alive on <b>1. 6. 1972</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(H)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rustum. Irani M.D.</b>			23B. DATE SIGNED <b>1. 6. 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>RUSTUM IRANI M.D.</b>			23D. ADDRESS <b>CHURCH HOME AND HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Gabley M.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph M. Zannino</b>	
				ADDRESS <b>263 S. Conkling Street</b>	

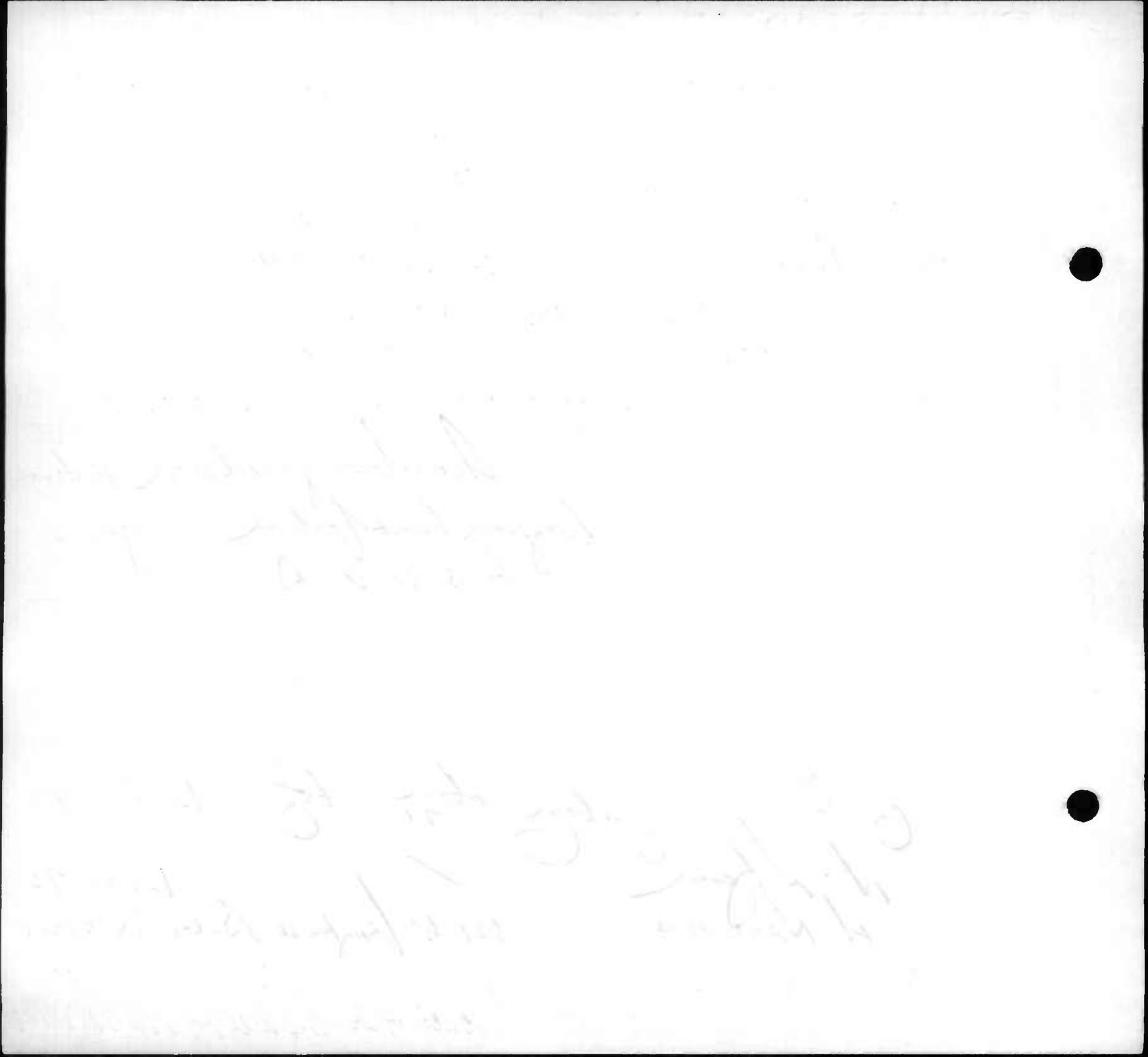




FUNERAL DIRECTOR: IMPORTANT

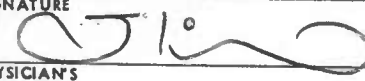
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

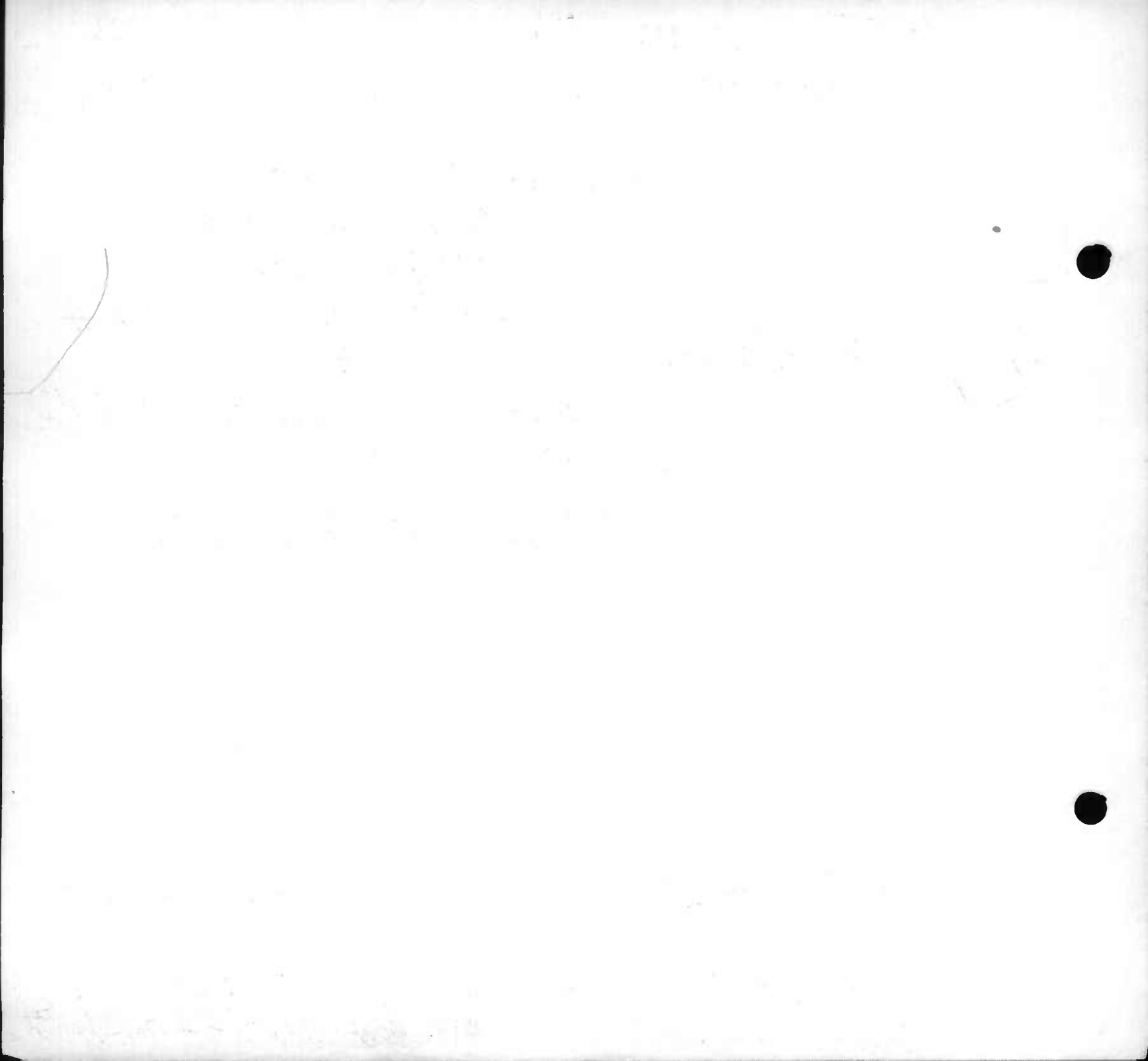
72 00222		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00222	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		GREEN CLEMONS		2. DATE AND HOUR OF DEATH JANUARY 6, 1972 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1901			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17 N. MOUNT STREET		E. STREET AND NUMBER 17 N. MOUNT STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1902	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Butcher Shop		11. BIRTHPLACE (State or foreign country) GREENVILLE, N.C.	
13. FATHER'S NAME GREEN CLEMONS		14. MOTHER'S MAIDEN NAME FRANCES MOORE		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-8995		17. INFORMANT ROWENA CLEMONS - 17 N. MOUNT STREET	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sudden coronary occlusion Longstanding heart failure (B) DUE TO, OR AS A CONSEQUENCE OF: H.S.C.V.D. (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from about 1965 to 1-6-1972 that (1) (we) last saw the deceased alive on about 1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 1-10-72			
23C. PHYSICIAN'S NAME (Type) H. NAKAZAWA		23D. ADDRESS 521 W. Lexington St. Balto Md 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/12/72		24C. NAME OF CEMETERY OR CREMATORY Hayes Chapel	
24D. LOCATION Greenspring		24E. (City, town, or county) M.C.			
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Orlinton S. Phillips	
				ADDRESS 1727 N. Mount St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-155		72 00223		BALTIMORE CITY HEALTH DEPARTMENT		72 00223	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>CHAPMAN DORIS</b>				2. DATE AND HOUR OF DEATH <b>11-55 PM 11/5/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2798</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4 SINAI HOSPITAL of BALTIMORE</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>5009 Cordelia Ave</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/23/37</b>	9. AGE (In years last birthday) <b>34</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign/country) <b>BALTO, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Winfield Battle</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Charms</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <b>413-32-9214</b>		17. INFORMANT <b>Frances Wilson</b>		ADDRESS <b>5009 Cordelia Ave</b>	
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RENAL FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA of CERVIX - Anaplastic</b> (B) POSSIBLE PULMONARY Metastasis DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED <b>11/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. F. H. Dietz</b>	
23D. ADDRESS <b>1201 - LAWRENCE ST</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-10-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Director Dietz F. H.</b>		ADDRESS <b>1201 - LAWRENCE ST</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00224</u>	
B-520 <u>72 00224</u>				CERTIFICATE OF DEATH	
BIRTH NO. <u>1</u>				2. DATE AND HOUR OF DEATH <u>1/8/72</u> M.	
1. NAME OF DECEASED (Type or Print) <u>BANKS, BETTY A.</u>				6. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>AA</u> <u>5210</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>				C. CITY OR TOWN <u>ANNAPOLIS</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>134 BESTGATE ROAD</u>	
5. SEX <u>female</u>	6. RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05/13/32</u>	9. AGE (In years last birthday) <u>39</u>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Library</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. Naval Acad.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Barker Hollie</u>				14. MOTHER'S MAIDEN NAME <u>HALL, LAURAX</u>	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mervan Banks-Anna. Md.</u>				ADDRESS	
18. <u>276 X I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Emboli</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Systemic Hypertension</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>1/1/30</u> 19 <u>72</u> to <u>1/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R A Rizza M.D.</u> DEGREE				23B. DATE SIGNED <u>1/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R A Rizza M.D.</u>				23D. ADDRESS <u>Johns Hopkins Hosp Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/13/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Fowler's</u>	
24D. LOCATION (City, town, or county) <u>Annapolis A.A. Md</u>		24E. STATE (State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>W. H. Reese, II</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Annapolis, Md.</u>	

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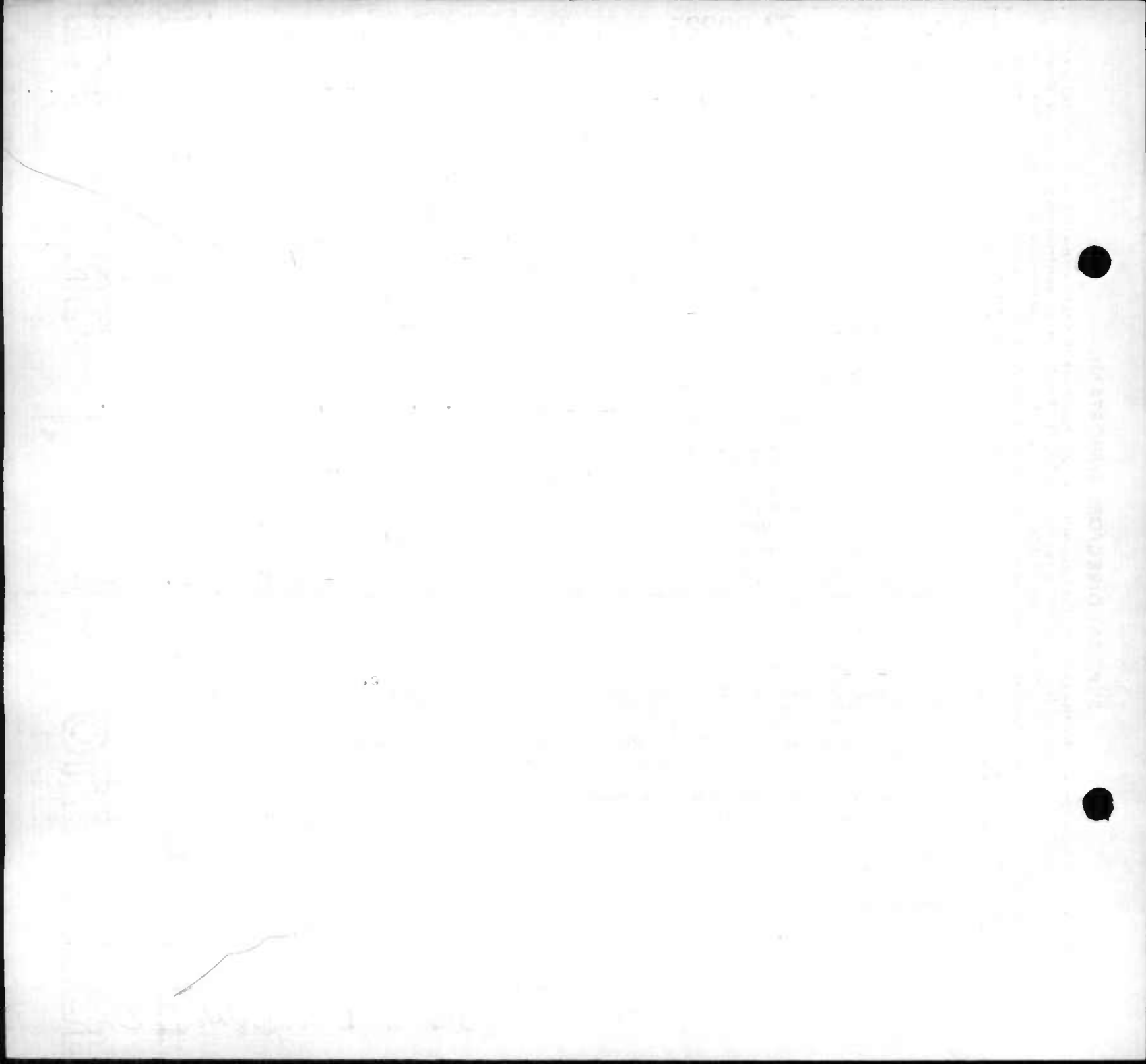
ST. LOUIS

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>X-246</u> <u>72 00225</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <u>X</u>		REG. NO. <u>72 00225</u>	
1. NAME OF DECEASED (Type or Print) <u>Paul Kugler SR.</u>				2. DATE AND HOUR OF DEATH <u>1-5-72</u> <u>7:15 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home &amp; Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> <u>5300</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>11 Vista Mobile Drive 21222</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-99</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Crane Operator - Steel</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Kugler</u>				14. MOTHER'S MAIDEN NAME <u>Christina Fredericks</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>				16. SOCIAL SECURITY NO. <u>215-10-0389</u>		17. INFORMANT ADDRESS <u>Mrs. A. Kugler, 11 Vista Mobile dr.</u>			
18. <u>150X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>				(A) IMMEDIATE CAUSE <u>Cardio- Respiratory Failure</u> <u>3 Hours</u> DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Metastases Liver, Possible in Lungs</u> <u>6 Months</u> DUE TO, OR AS A CONSEQUENCE OF:					
				(C) <u>Carcinoma of Esophago- Cardiac Junc.</u> <u>Uncertain Duration</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Renal failure, ? Leak from Esophagus</u>									
19A. DATE OF OPERATION <u>3 12-29-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of Esophago Gastric Junc.</u>		20A. AUTOPSY (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>12-12-1971</u> to <u>1-5-1972</u> that (I) (we) last saw the deceased alive on <u>1-5-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Prabir K. Bose</u> MD DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>1-7-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>PRABIR K. BOSE</u> <u>Dr. Jose Yosuico</u> MD DEGREE				23D. ADDRESS <u>Church Home &amp; Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan 8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadow Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>John E. Kelly</u>		25C. FUNERAL DIRECTOR <u>William J. Zindel</u>		ADDRESS <u>Home Dundalk</u>			

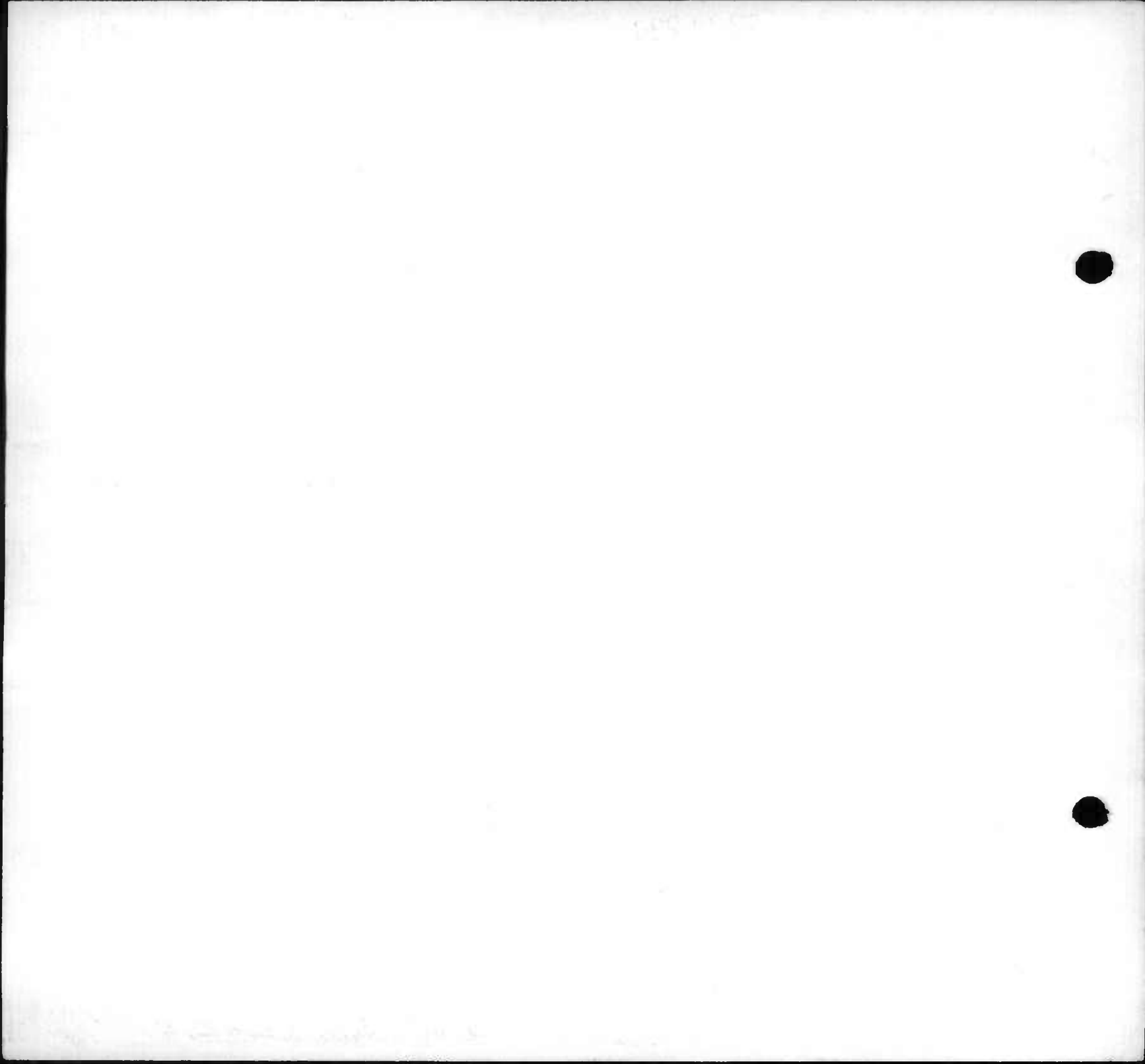




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00226</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>McCREADY ELIZABETH</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>1/2/1972 at 5:45 A.M.</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Lutheran Hospital of Maryland</u> <u>730 Ashburton</u> <u>Baltimore, Md. 21216.</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21216.</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2107 Ellamont St.</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/24/1898</u>		<b>9. AGE</b> (In years last birthday) <u>73</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<b>13. FATHER'S NAME</b>			<b>14. MOTHER'S MAIDEN NAME</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 35%;"> <b>(A) IMMEDIATE CAUSE</b> <u>Chronic renal failure</u>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <u>with Uremia</u>   <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>   <b>(C)</b> </div> <div style="width: 5%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <u>1 yr.</u> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Diabetes</u>					
<b>19A. DATE OF OPERATION</b> <u>5</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If not medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/20/1971</u> <b>19</b> <b>to</b> <u>1/2/1972</u> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <u>1/2/1972</u> <b>19</b> <b>and that (in my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>[Signature]</u>		<b>23B. DATE SIGNED</b> <u>1/2/1971</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>SURESH PENKAR</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <u>1-7-72</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Woodlawn</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 10 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>[Signature]</u>		<b>25C. FUNERAL DIRECTOR</b> <u>[Signature]</u>	
<b>ADDRESS</b> <u>1701 N. BOND ST</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-352		72 00227		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00227	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ADAMS, James Herbert</b>				2. DATE AND HOUR OF DEATH <b>1-4-72</b> <b>3:30 a.m.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>807</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1439 North Bond Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-15-95</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Culpepper, Va</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Adams</b>				14. MOTHER'S MAIDEN NAME <b>Lillie M. Adams</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 17 to 19</b>				16. SOCIAL SECURITY NO. <b>672-80-0044</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>Baltimore, Maryland 21218</b>	
18. <b>776.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>infection and/or adrenal failure</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>infection and/or adrenal failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 27, 1971</b> to <b>January 4, 1972</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 4, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <del>not</del> view the body after death.							
23A. SIGNATURE <i>Donald E. Klug, M.D.</i> DONALD KLUG, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>2/4/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONALD KLUG, M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Maryland National Park</b>		24D. LOCATION (City, town, or county) (State) <b>Sever, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Williams</b>		25C. FUNERAL DIRECTOR <b>1701 N Bond St 21213</b>		ADDRESS	

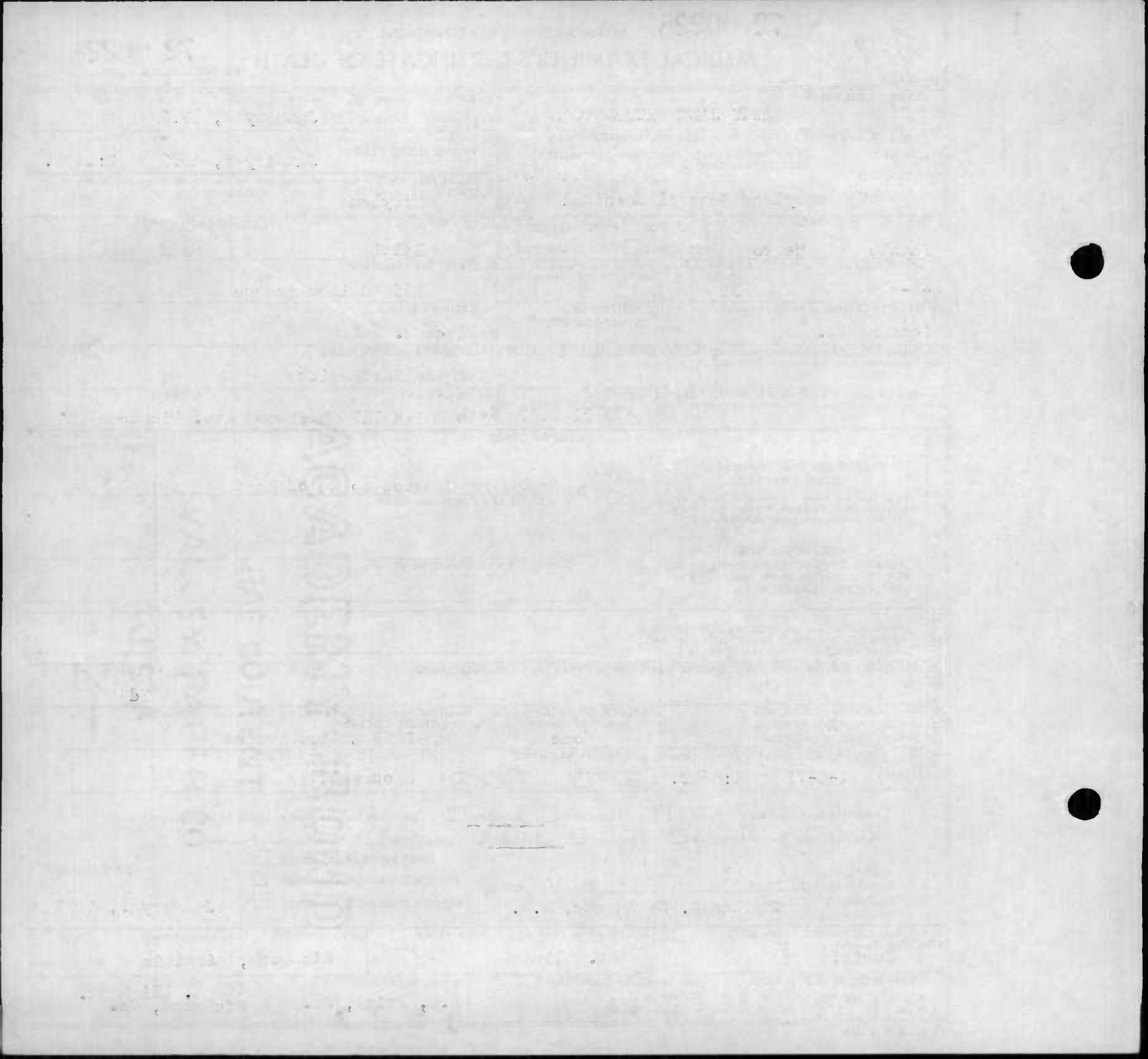


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>BETTY JANE WITHERSPOON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>January</b> Day <b>8</b> Year <b>1972</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) <b>Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>8</b> Year <b>1972</b> Hour <b>2:10 P.</b> M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6-3-40</b>		10. AGE (In years lost birthday) <b>31</b>	
11. BIRTHPLACE (State or foreign country) <b>Richmond Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wallace J. Smith</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1301</b>	
15. MOTHER'S MAIDEN NAME <b>Ruth Hubbard Smith</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>179 32 0087</b>		18. INFORMANT <b>Ruth Smith</b> ADDRESS <b>717 Cheatwood Ave. Richmond Va.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2/8/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2458 Callow Avenue 1301</b>			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>1-8-72 1:45 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Shot self</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>January 9, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet</b>		24D. LOCATION (City, town, or county) (State) <b>Richmond, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>A.D. Price, Jr.</b>		25D. ADDRESS <b>208 E. Leigh St. Richmond, Va.</b>	





BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <u>CLARENCE A. WYATT</u> Junior				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>January</u> Day <u>8</u> Year <u>1972</u> Hour <u>4:10</u> P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital (DOA)</u>				3. DATE PRONOUNCED DEAD Month <u>January</u> Day <u>8</u> Year <u>1972</u> Hour <u>4:10</u> P.M.			
6. SEX <u>Male</u>		7. RACE <u>White</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Waldorf</u>	
9. DATE OF BIRTH <u>6-17-20</u>		10. AGE (In years last birthday) <u>51</u>		If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <u>Route 4, Box 65 E Gillespie Trailer Park</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clarence Wyatt, Sr.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				14B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		15. MOTHER'S MAIDEN NAME <u>Altha Lunsford Read</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW II Navy</u>				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <u>J.F. Floyd Mortuary, Spartanburg, S.C.</u>	
MEDICAL CERTIFICATION 19. <u>E-814.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____ DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <u>2</u>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>US #301, Mattawoman, Md. (Charles Co.)</u>	
22D. TIME OF INJURY (APPROX.) Month <u>1</u> Day <u>8</u> Year <u>72</u> Hour <u>1:21</u> P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Pedestrian struck by auto</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>January 9, 1972</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>1-12-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenlawn Mem. Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Spartanburg, S.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Smith, Reg. No. 0000</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins Sons Co.</u>		ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>	

CROP		PLANTING DATE		HARVEST DATE		YIELD		TOTAL	
WHEAT		MAY 15		JULY 15		100		100	
BARLEY		MAY 20		JULY 20		80		80	
OATS		MAY 25		JULY 25		60		60	
RICE		JUNE 1		AUG 1		120		120	
SUGAR BEET		JUNE 5		AUG 5		90		90	
CORN		JUNE 10		AUG 10		110		110	
SOYBEANS		JUNE 15		AUG 15		105		105	
COTTON		JUNE 20		AUG 20		95		95	
PEANUTS		JUNE 25		AUG 25		85		85	
SUNFLOWER		JULY 1		SEP 1		75		75	
MILK		JULY 5		SEP 5		100		100	
EGGS		JULY 10		SEP 10		90		90	
PORK		JULY 15		SEP 15		80		80	
BEEF		JULY 20		SEP 20		70		70	
LAMB		JULY 25		SEP 25		60		60	
CHICKEN		AUG 1		OCT 1		50		50	
DUCK		AUG 5		OCT 5		40		40	
GOOSE		AUG 10		OCT 10		30		30	
TURKEY		AUG 15		OCT 15		20		20	
PHEASANT		AUG 20		OCT 20		10		10	
QUAIL		AUG 25		OCT 25		5		5	
SQUAB		SEP 1		NOV 1		15		15	
DRAKE		SEP 5		NOV 5		10		10	
GEESE		SEP 10		NOV 10		5		5	
DUCK		SEP 15		NOV 15		5		5	
PHEASANT		SEP 20		NOV 20		5		5	
QUAIL		SEP 25		NOV 25		5		5	
SQUAB		OCT 1		DEC 1		15		15	
DRAKE		OCT 5		DEC 5		10		10	
GEESE		OCT 10		DEC 10		5		5	
DUCK		OCT 15		DEC 15		5		5	
PHEASANT		OCT 20		DEC 20		5		5	
QUAIL		OCT 25		DEC 25		5		5	
SQUAB		NOV 1		JAN 1		15		15	
DRAKE		NOV 5		JAN 5		10		10	
GEESE		NOV 10		JAN 10		5		5	
DUCK		NOV 15		JAN 15		5		5	
PHEASANT		NOV 20		JAN 20		5		5	
QUAIL		NOV 25		JAN 25		5		5	
SQUAB		DEC 1		FEB 1		15		15	
DRAKE		DEC 5		FEB 5		10		10	
GEESE		DEC 10		FEB 10		5		5	
DUCK		DEC 15		FEB 15		5		5	
PHEASANT		DEC 20		FEB 20		5		5	
QUAIL		DEC 25		FEB 25		5		5	
SQUAB		JAN 1		MAR 1		15		15	
DRAKE		JAN 5		MAR 5		10		10	
GEESE		JAN 10		MAR 10		5		5	
DUCK		JAN 15		MAR 15		5		5	
PHEASANT		JAN 20		MAR 20		5		5	
QUAIL		JAN 25		MAR 25		5		5	
SQUAB		FEB 1		APR 1		15		15	
DRAKE		FEB 5		APR 5		10		10	
GEESE		FEB 10		APR 10		5		5	
DUCK		FEB 15		APR 15		5		5	
PHEASANT		FEB 20		APR 20		5		5	
QUAIL		FEB 25		APR 25		5		5	
SQUAB		MAR 1		MAY 1		15		15	
DRAKE		MAR 5		MAY 5		10		10	
GEESE		MAR 10		MAY 10		5		5	
DUCK		MAR 15		MAY 15		5		5	
PHEASANT		MAR 20		MAY 20		5		5	
QUAIL		MAR 25		MAY 25		5		5	
SQUAB		APR 1		JUN 1		15		15	
DRAKE		APR 5		JUN 5		10		10	
GEESE		APR 10		JUN 10		5		5	
DUCK		APR 15		JUN 15		5		5	
PHEASANT		APR 20		JUN 20		5		5	
QUAIL		APR 25		JUN 25		5		5	
SQUAB		MAY 1		JUL 1		15		15	
DRAKE		MAY 5		JUL 5		10		10	
GEESE		MAY 10		JUL 10		5		5	
DUCK		MAY 15		JUL 15		5		5	
PHEASANT		MAY 20		JUL 20		5		5	
QUAIL		MAY 25		JUL 25		5		5	
SQUAB		JUN 1		AUG 1		15		15	
DRAKE		JUN 5		AUG 5		10		10	
GEESE		JUN 10		AUG 10		5		5	
DUCK		JUN 15		AUG 15		5		5	
PHEASANT		JUN 20		AUG 20		5		5	
QUAIL		JUN 25		AUG 25		5		5	
SQUAB		JUL 1		SEP 1		15		15	
DRAKE		JUL 5		SEP 5		10		10	
GEESE		JUL 10		SEP 10		5		5	
DUCK		JUL 15		SEP 15		5		5	
PHEASANT		JUL 20		SEP 20		5		5	
QUAIL		JUL 25		SEP 25		5		5	
SQUAB		AUG 1		OCT 1		15		15	
DRAKE		AUG 5		OCT 5		10		10	
GEESE		AUG 10		OCT 10		5		5	
DUCK		AUG 15		OCT 15		5		5	
PHEASANT		AUG 20		OCT 20		5		5	
QUAIL		AUG 25		OCT 25		5		5	
SQUAB		SEP 1		NOV 1		15		15	
DRAKE		SEP 5		NOV 5		10		10	
GEESE		SEP 10		NOV 10		5		5	
DUCK		SEP 15		NOV 15		5		5	
PHEASANT		SEP 20		NOV 20		5		5	
QUAIL		SEP 25		NOV 25		5		5	
SQUAB		OCT 1		DEC 1		15		15	
DRAKE		OCT 5		DEC 5		10		10	
GEESE		OCT 10		DEC 10		5		5	
DUCK		OCT 15		DEC 15		5		5	
PHEASANT		OCT 20		DEC 20		5		5	
QUAIL		OCT 25		DEC 25		5		5	
SQUAB		NOV 1		JAN 1		15		15	
DRAKE		NOV 5		JAN 5		10		10	
GEESE		NOV 10		JAN 10		5		5	
DUCK		NOV 15		JAN 15		5		5	
PHEASANT		NOV 20		JAN 20		5		5	
QUAIL		NOV 25		JAN 25		5		5	
SQUAB		DEC 1		FEB 1		15		15	
DRAKE		DEC 5		FEB 5		10		10	
GEESE		DEC 10		FEB 10		5		5	
DUCK		DEC 15		FEB 15		5		5	
PHEASANT		DEC 20		FEB 20		5		5	
QUAIL		DEC 25		FEB 25		5		5	
SQUAB		JAN 1		MAR 1		15		15	
DRAKE		JAN 5		MAR 5		10		10	
GEESE		JAN 10		MAR 10		5		5	
DUCK		JAN 15		MAR 15		5		5	
PHEASANT		JAN 20		MAR 20		5		5	
QUAIL		JAN 25		MAR 25		5		5	
SQUAB		FEB 1		APR 1		15		15	
DRAKE		FEB 5		APR 5		10		10	
GEESE		FEB 10		APR 10		5		5	
DUCK		FEB 15		APR 15		5		5	
PHEASANT		FEB 20		APR 20		5		5	
QUAIL		FEB 25		APR 25		5		5	
SQUAB		MAR 1		MAY 1		15		15	
DRAKE		MAR 5		MAY 5		10		10	
GEESE		MAR 10		MAY 10		5		5	
DUCK		MAR 15		MAY 15		5		5	
PHEASANT		MAR 20		MAY 20		5		5	
QUAIL		MAR 25		MAY 25		5		5	
SQUAB		APR 1		JUN 1		15		15	
DRAKE		APR 5		JUN 5		10		10	
GEESE		APR 10		JUN 10		5		5	
DUCK		APR 15		JUN 15		5		5	
PHEASANT		APR 20		JUN 20		5		5	
QUAIL		APR 25		JUN 25		5		5	
SQUAB		MAY 1		JUL 1		15		15	
DRAKE		MAY 5		JUL 5		10		10	
GEESE		MAY 10		JUL 10		5		5	
DUCK		MAY 15		JUL 15		5		5	
PHEASANT		MAY 20		JUL 20		5		5	
QUAIL		MAY 25		JUL 25		5		5	
SQUAB		JUN 1		AUG 1		15		15	
DRAKE		JUN 5		AUG 5		10		10	
GEESE		JUN 10		AUG 10		5		5	
DUCK		JUN 15		AUG 15		5		5	
PHEASANT		JUN 20		AUG 20		5		5	
QUAIL		JUN 25		AUG 25		5		5	
SQUAB		JUL 1		SEP 1		15		15	
DRAKE		JUL 5		SEP 5		10		10	
GEESE		JUL 10		SEP 10		5		5	
DUCK		JUL 15		SEP 15		5		5	
PHEASANT		JUL 20		SEP 20		5		5	
QUAIL		JUL 25		SEP 25		5		5	
SQUAB		AUG 1		OCT 1		15		15	
DRAKE		AUG 5		OCT 5		10		10	
GEESE		AUG 10		OCT 10		5		5	
DUCK		AUG 15		OCT 15		5		5	
PHEASANT		AUG 20		OCT 20		5		5	
QUAIL		AUG 25		OCT 25		5		5	
SQUAB		SEP 1		NOV 1		15		15	
DRAKE		SEP 5		NOV 5		10		10	
GEESE		SEP 10		NOV 10		5		5	
DUCK		SEP 15		NOV 15		5		5	
PHEASANT		SEP 20		NOV 20		5		5	
QUAIL		SEP 25		NOV 25		5		5	
SQUAB		OCT 1		DEC 1		15		15	
DRAKE		OCT 5		DEC 5		10		10	
GEESE		OCT 10		DEC 10		5		5	
DUCK		OCT 15		DEC 15		5		5	
PHEASANT		OCT 20		DEC 20		5		5	
QUAIL		OCT 25		DEC 25		5		5	
SQUAB		NOV 1		JAN 1		15		15	
DRAKE		NOV 5		JAN 5		10		10	
GEESE		NOV 10		JAN 10		5		5	
DUCK		NOV 15		JAN 15		5		5	
PHEASANT		NOV 20		JAN 20		5		5	
QUAIL		NOV 25		JAN 25		5		5	
SQUAB		DEC 1		FEB 1		15		15	
DRAKE		DEC 5		FEB 5		10		10	
GEESE		DEC 10		FEB 10		5		5	
DUCK		DEC 15		FEB 15		5		5	
PHEASANT		DEC 20		FEB 20		5		5	
QUAIL		DEC 25		FEB 25		5		5	
SQUAB		JAN 1		MAR 1		15		15	
DRAKE		JAN 5		MAR 5		10		10	
GEESE		JAN 10		MAR 10		5		5	
DUCK		JAN 15		MAR 15		5		5	
PHEASANT		JAN 20		MAR 20		5		5	
QUAIL		JAN 25		MAR 25		5		5	
SQUAB		FEB 1		APR 1		15		15	
DRAKE		FEB 5		APR 5		10		10	
GEESE		FEB 10		APR 10		5		5	
DUCK		FEB 15		APR 15		5		5	
PHEASANT		FEB 20		APR 20		5		5	
QUAIL		FEB 25		APR 25		5		5	
SQUAB		MAR 1		MAY 1		15		15	
DRAKE		MAR 5		MAY 5		10		10	
GEESE		MAR 10		MAY 10		5		5	
DUCK		MAR 15		MAY 15		5		5	
PHEASANT		MAR 20		MAY 20		5		5	
QUAIL		MAR 25		MAY 25		5		5	
SQUAB		APR 1		JUN 1		15		15	
DRAKE		APR 5		JUN 5		10		10	
GEESE		APR 10		JUN 10		5		5	
DUCK		APR 15		JUN					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-130 72 00230		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00230	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES T. ABBOTT</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 8, 1972 9:50 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>BALTIMORE 21234</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSP.</u> <u>48</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-21-10</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK EMPLOYEE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM O. ABBOTT</u>		14. MOTHER'S MAIDEN NAME <u>ISABELL STOUT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-14-1233</u>		17. INFORMANT <u>MRS. BERTHA M. ABBOTT (SAME)</u>	
18. <u>4-10-71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PROGRESSIVE DEGENERATIVE BRAIN DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 HRS.</u> <u>24 HRS.</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>INJURY OCCURRED</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>JANUARY 7 1972</u> to <u>JANUARY 8 1972</u> that (1) (we) last saw the deceased alive on <u>JANUARY 8 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard H. Balcer M.D.</u>		23B. DATE SIGNED <u>JAN. 8, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD H. BALCER M.D.</u>	
23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-12-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Stevensville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>	
25B. NAME OF REGISTRAR <u>W. Jenkins Sons Co.</u>		25C. FUNERAL DIRECTOR <u>W. Jenkins Sons Co.</u>		ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>	

1.1.1.1

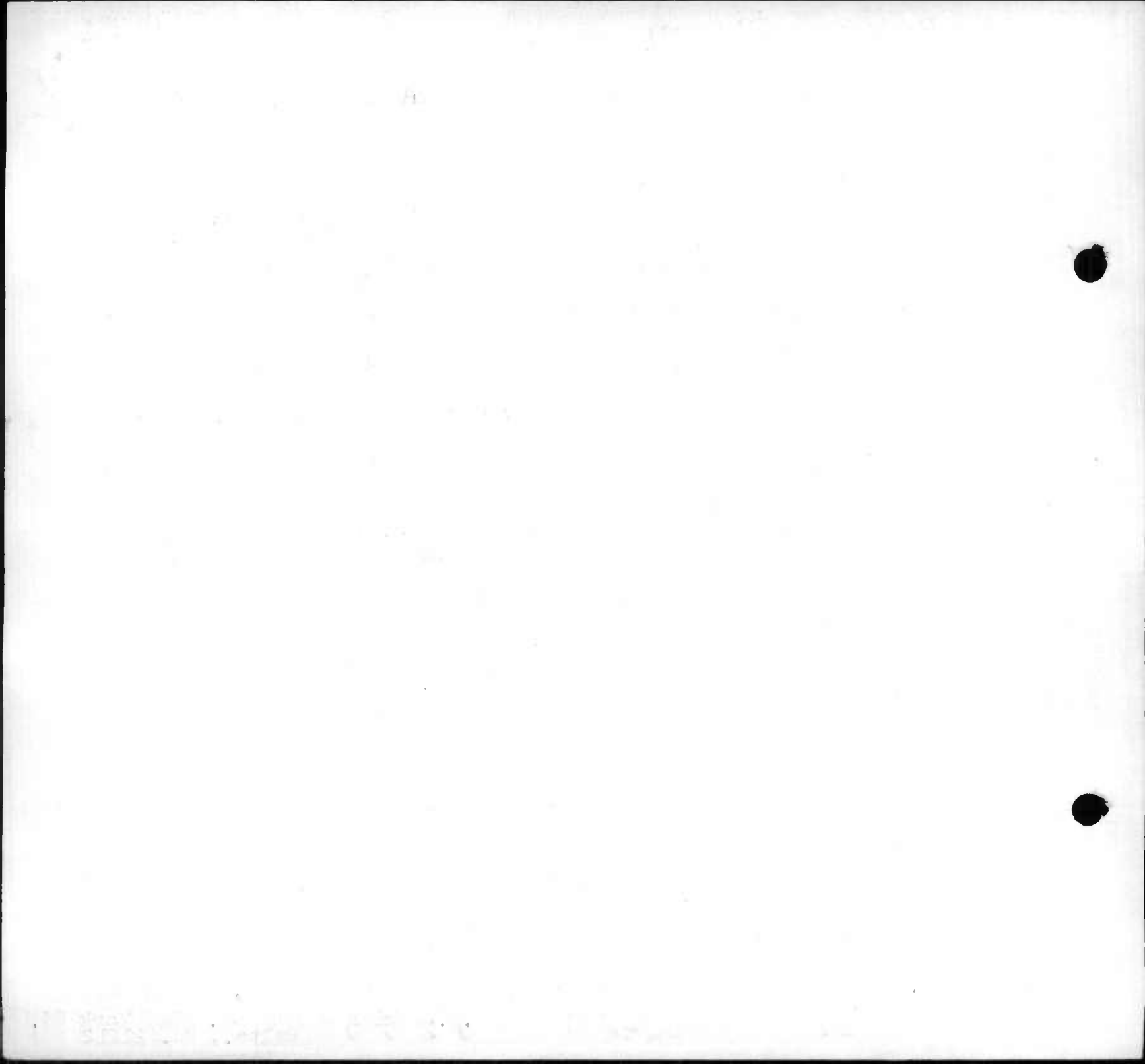
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FUNERAL DIRECTOR: IMPORTANT

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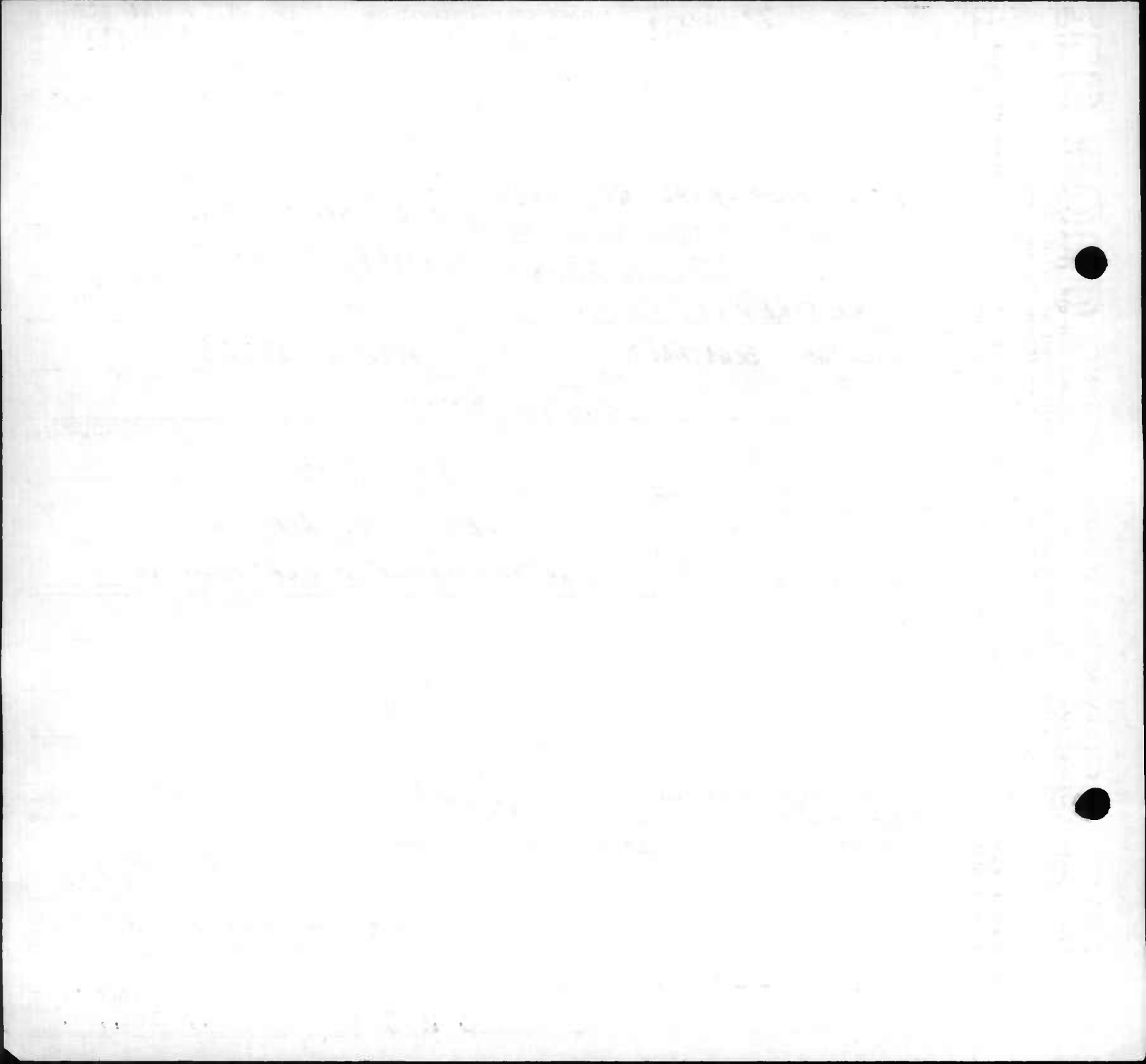
H-363 72 00231		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00231	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hetherton, Faith</u>		2. DATE AND HOUR OF DEATH <u>ESTEL January 8, 1972 2:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1202</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles Gen. Hospital</u> <u>49</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>302 E. University Pkwy</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3 1878</u>	9. AGE (In years last birthday) <u>94</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George W. Brannon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Betty -</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-44-1480</u>		17. INFORMANT <u>GEORGE H. BRANNAN</u> ADDRESS <u>(SAME)</u>	
18. <u>560.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BILATERAL LOBAR PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>SMALL INTESTINAL OBSTRUCTION</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA</u> (B) <u>SMALL INTESTINAL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-17-71</u> <u>12-23-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal Obstruction</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>HE</u> (this hospital) attended the deceased from <u>12-17-1971</u> to <u>1-8-1972</u> that <u>HE</u> (we) last saw the deceased alive on <u>1-8-1972</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HE</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Narciso A. de Borja</u> MD DEGREE		23B. DATE SIGNED <u>1-8-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Narciso A. de Borja</u> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>1/11/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>River View</u>	
24D. LOCATION <u>Wilmington, Delaware</u>		24E. ADDRESS <u>North Charles Gen. Hosp Baltimore Md.</u>		24F. ADDRESS <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1972</u>		25B. NAME OF REGISTRAR <u>2688 307 7 0 0 0</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

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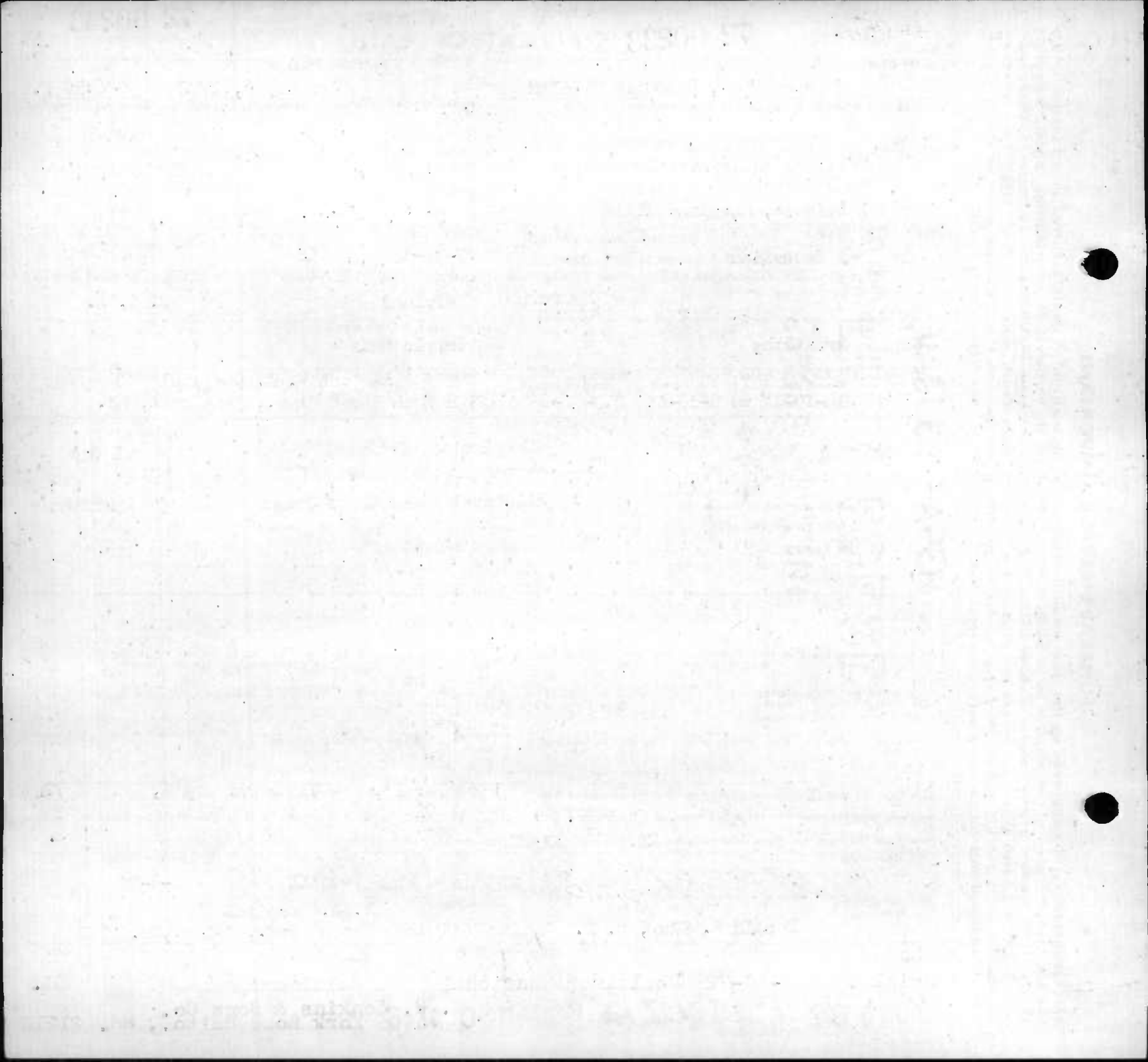
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">B-452</span>					REG. NO. <span style="float: right;">72 00232</span>				
1. NAME OF DECEASED (Type or Print) <b>RAE BLANCHARD</b>					2. DATE AND HOUR OF DEATH <b>1/7/72</b> <span style="float: right;">11 P.M.</span>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1202</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>					C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <b>3333 N. CHARLES STREET</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/29/89</b>	9. AGE (In years last birthday) <b>82</b>	11. Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		11. BIRTHPLACE (State or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM BLANCHARD</b>					14. MOTHER'S MAIDEN NAME <b>MYRTLE JONES</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-303765</b>		17. INFORMANT <b>RECORDS</b>			ADDRESS
18. <b>41241</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/7/71</b> 19__ to <b>1/7/72</b> 19__ that (I) (we) last saw the deceased alive on <b>1/7/72</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>R. J. BUSTO MD</b>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>1/9/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. J. BUSTO MD</b>					23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>			24B. DATE <b>1-8-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>			25B. NAME OF REGISTRAR <b>R. J. BUSTO</b>			25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co., Balto., Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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A-652 72 00233				BALTIMORE CITY HEALTH DEPARTMENT		72 00233	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ARMSTRONG, RANDOLPH WILLIAM				January 6, 1972 6:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Male Caucasian WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Sexton St. Marks Lutheran Church 23 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Eugene Armstrong				Carrie Haas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes 10-19-42 to 9-19-45				213-07-6875		Records V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Respiratory failure			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF: Bilateral adeno Ca of lungs			
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				1 Day			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from December 13, 19 71 to January 6, 19 72, that (X) (we) last saw the deceased alive on January 6, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				23A. SIGNATURE			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		23B. DATE SIGNED	
Donald E. Klug, M. D.				V. A. Hospital 3900 Loch Raven Blvd., Balto., Md. 21218		1-6-72	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-10-72		Baltimore National		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 10 1972		J. B. J. 0 0 0		H. W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212	

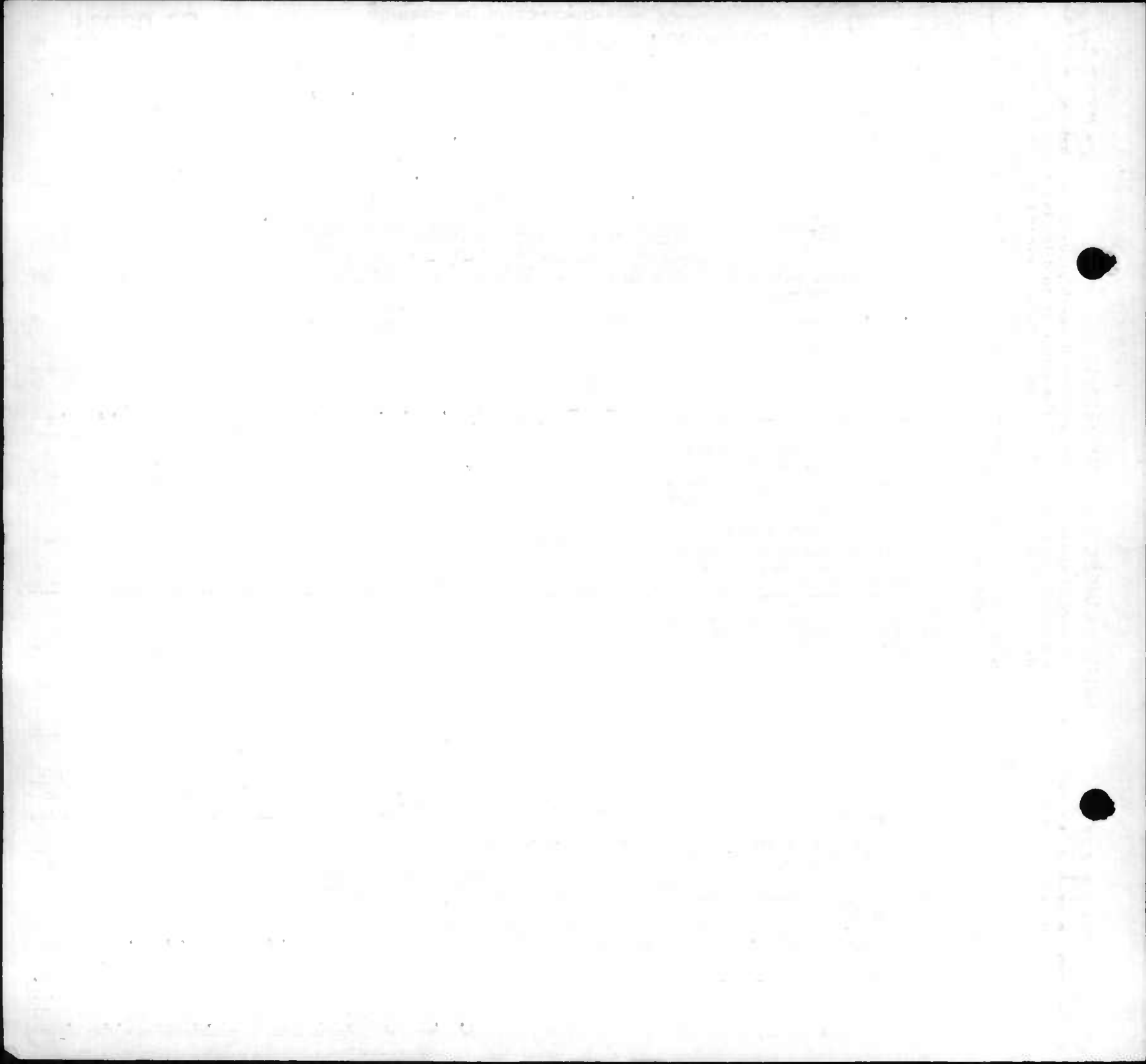




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00234</u>	
S-320 72 00234				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Anne Haxall Sheets</u>		2. DATE AND HOUR OF DEATH <u>Jan. 6, 1972</u> <u>9:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2713</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 706 Gladstone Ave.</u>			C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>706 Gladstone Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1893</u>	9. AGE (In years last birthday) <u>78</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. N.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Triplett Haxall</u>		
14. MOTHER'S MAIDEN NAME <u>Rose Gordon</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>A 219-16-5287</u>			17. INFORMANT <u>Mrs. L.B. Fanneman</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute heart attack</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute heart attack</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>			(C) <u>ASCVD</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indefinitely medical examined)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> 19 <u>70</u> to <u>January 6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>January 5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William G. Helfrich</u>				23B. DATE SIGNED <u>1-7-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William G. Helfrich MD</u>				23D. ADDRESS <u>5006 Roland Ave., Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-10-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederickburg Va.</u>		25A. DATE REC'D. BY HEALTH DEPT. <u>JAN 10 1972</u>			
25B. NAME OF REGISTRAR <u>HOW Jenkins</u>		25C. FUNERAL DIRECTOR <u>HOW Jenkins &amp; Sons CO., Balto., Md.</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00235

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Glen D. Davis

2. DATE

Known ☒

Month

Day

Year

Hour

OF  
DEATHEstimated ☐

1

7

72

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

1

7

72

3:00 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

2802

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

7/14/53

10. AGE (In years last birthday)

18

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

5504 W. Wesley Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Davis

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Adrienne Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

217-62-2084

18. INFORMANT

ADDRESS

Benjamin Davis 5504 Wesley Ave.

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Narcotic addiction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/7/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/10/72

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

(State)

Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 10 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Charles A. Rice

ADDRESS

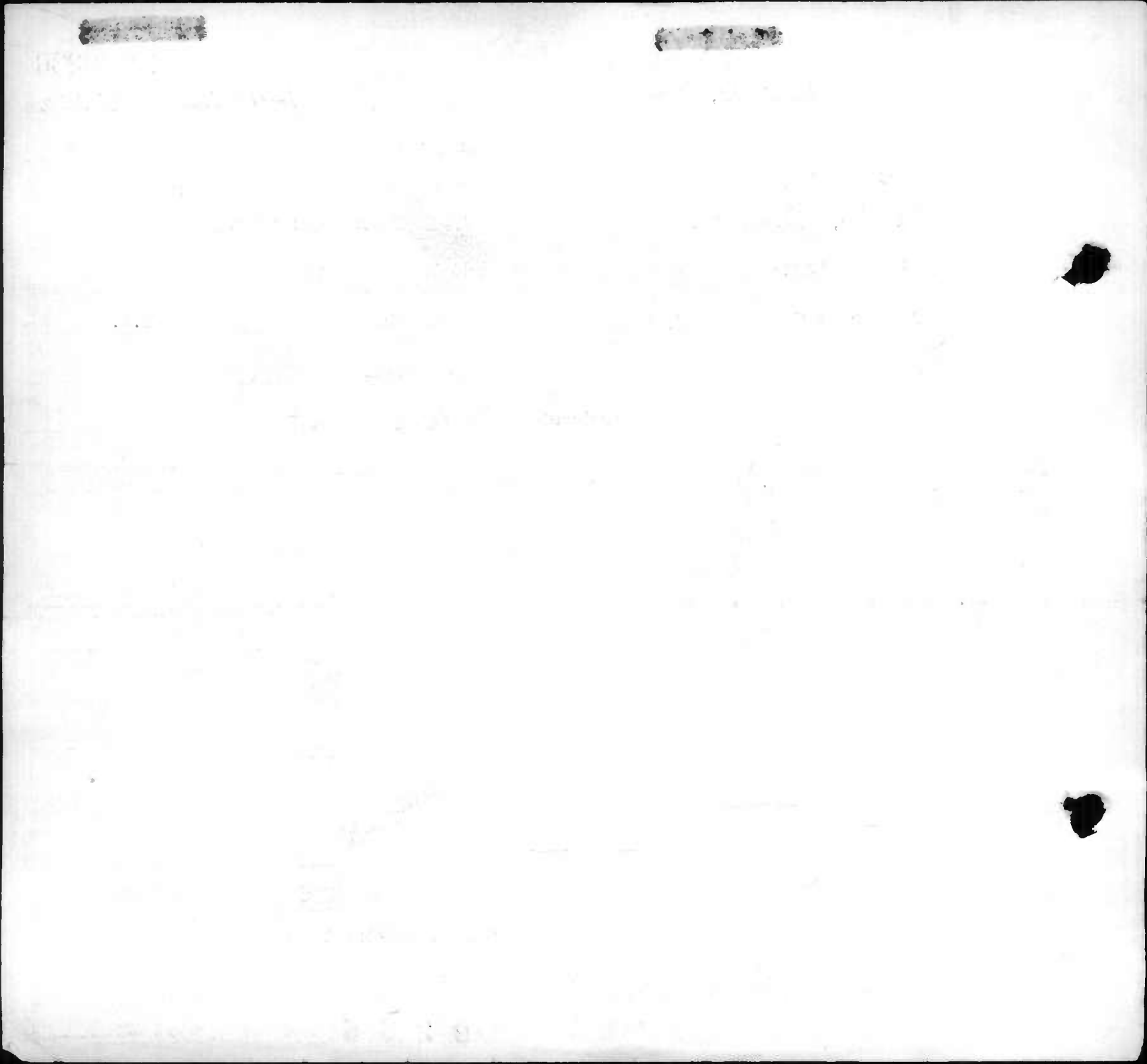
661 W. Barre St.

1-14-72 - Letter from - Office of the Chief Medical Examiner, Peter Lipkovic, M.D.  
Assistant Medical Examiner

HRS

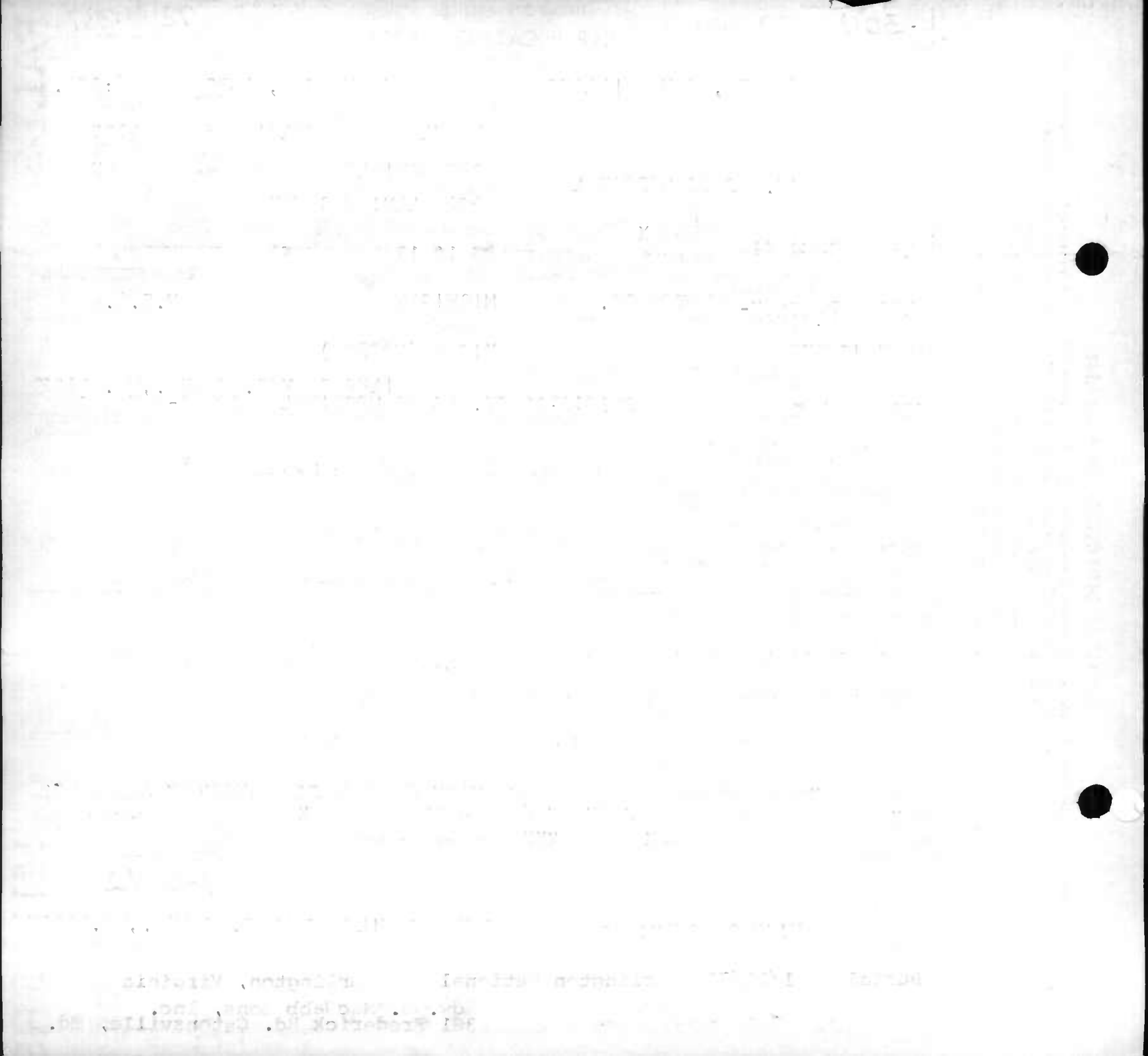
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-300 72 00237				BALTIMORE CITY HEALTH DEPARTMENT		72 00237	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JEWETT, JOHN WILLITS</b>				JANUARY 6, 1972 6:35A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE</b>	
				C. CITY OR TOWN <b>CATONSVILLE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>404 ALLVIEW COURT</b>			
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>05 13 17</b>	
9. AGE (In years last birthday) <b>54</b>		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES REPRESENTATIVE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>MOTOR CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>	
13. FATHER'S NAME <b>HENRY JEWETT</b>				14. MOTHER'S MAIDEN NAME <b>XISRA (HOOPER)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW2</b>		16. SOCIAL SECURITY NO. <b>383013732</b>		17. INFORMANT <b>WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &amp;</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.91</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Acute Myocardial Infarction</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Edema</b>			
				(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Old Myocardial Infarction</b>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 6</b> 19 <b>72</b> to <b>JANUARY 6</b> 19 <b>72</b> that (X) (we) last saw the deceased alive on <b>JANUARY 6</b> 19 <b>72</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dX) (XX) view the body after death.							
23A. SIGNATURE <b>Benaides</b>				23B. DATE SIGNED <b>1-6-72</b>		23C. PHYSICIAN'S NAME (Type) <b>VICTOR BENAVIDES</b>	
23D. ADDRESS <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>				23E. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons, Inc.</b>		23F. ADDRESS <b>381 Frederick Rd. Catonsville, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/10/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington National</b>		24D. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>2009 J. B. 748 0 0 0</b>		25C. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons, Inc.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 72 00238					REG. NO. 72 00238					
BIRTH NO.					BIRTH NO.					
1. NAME OF DECEASED (Type or Print) POPE, WILLIAM RUSSELL					2. DATE AND HOUR OF DEATH JANUARY 6, 1972 12:30A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 21 B MONTROSE MANOR COURT 5300										
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08 24 19	9. AGE (In years last birthday) 52	10. Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN			10B. KIND OF BUSINESS OR INDUSTRY CARPENTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH POPE					14. MOTHER'S MAIDEN NAME EFFIE (LAYTON)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2			16. SOCIAL SECURITY NO. 219-01-1705		17. INFORMANT WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF: (C)					
19. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 23 19 71 to JANUARY 6 19 72 that (X) (we) last saw the deceased alive on JANUARY 6 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (d) (X) view the body after death.										
23A. SIGNATURE Eitatsu Henzan M.D.					23B. DATE SIGNED 1/6/72			23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/8/72		24C. NAME OF CEMETERY or CREMATORY Mountain View		24D. LOCATION (City, town, or county) (State) Howard Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 11 1972			25B. NAME OF REGISTRAR Edw. S. MacNabb Sons, Inc.		25C. FUNERAL DIRECTOR ADDRESS 301 Frederick Rd. Catonsville, Md.					

212-01-1702

Howard D. ...

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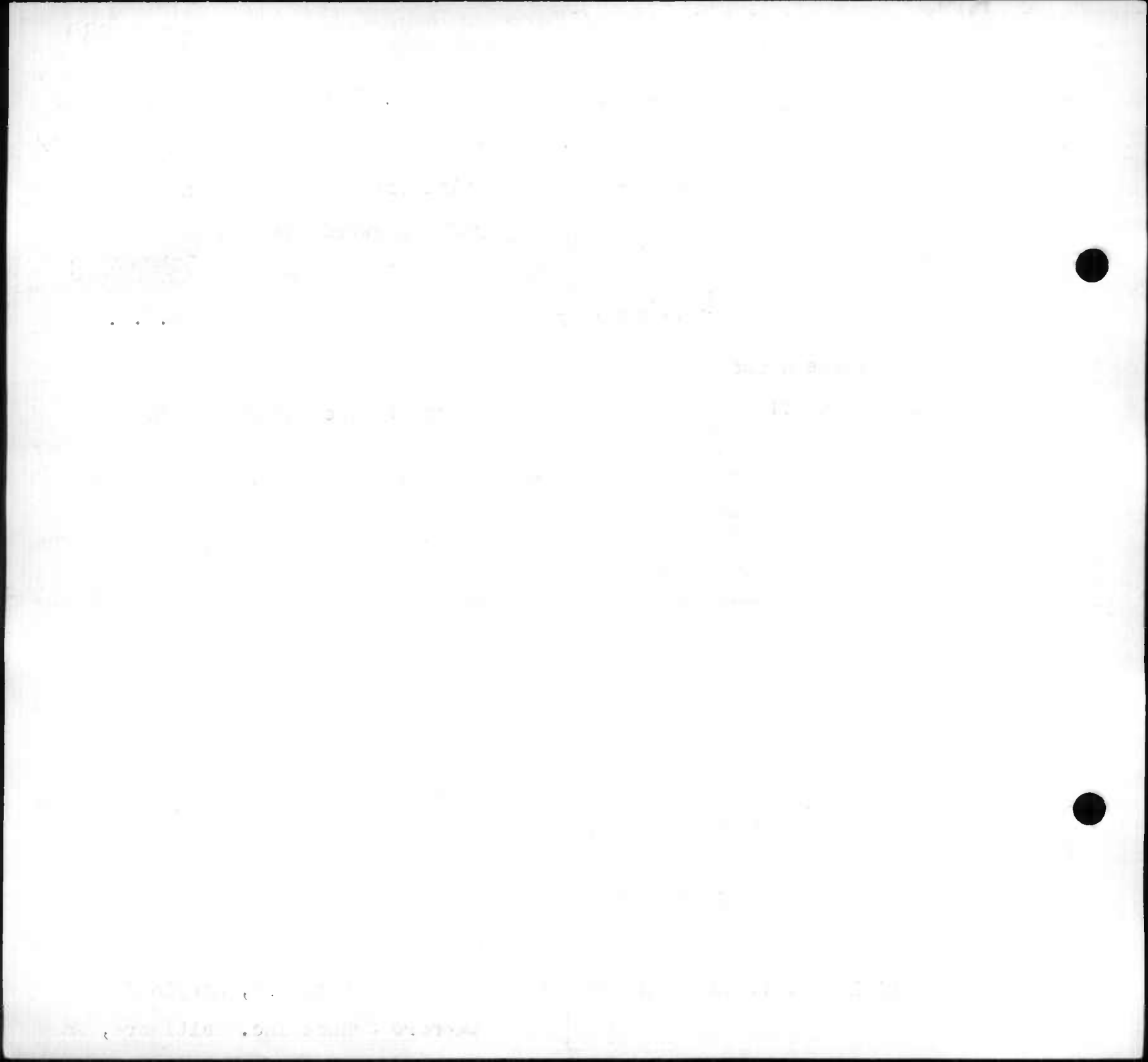
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

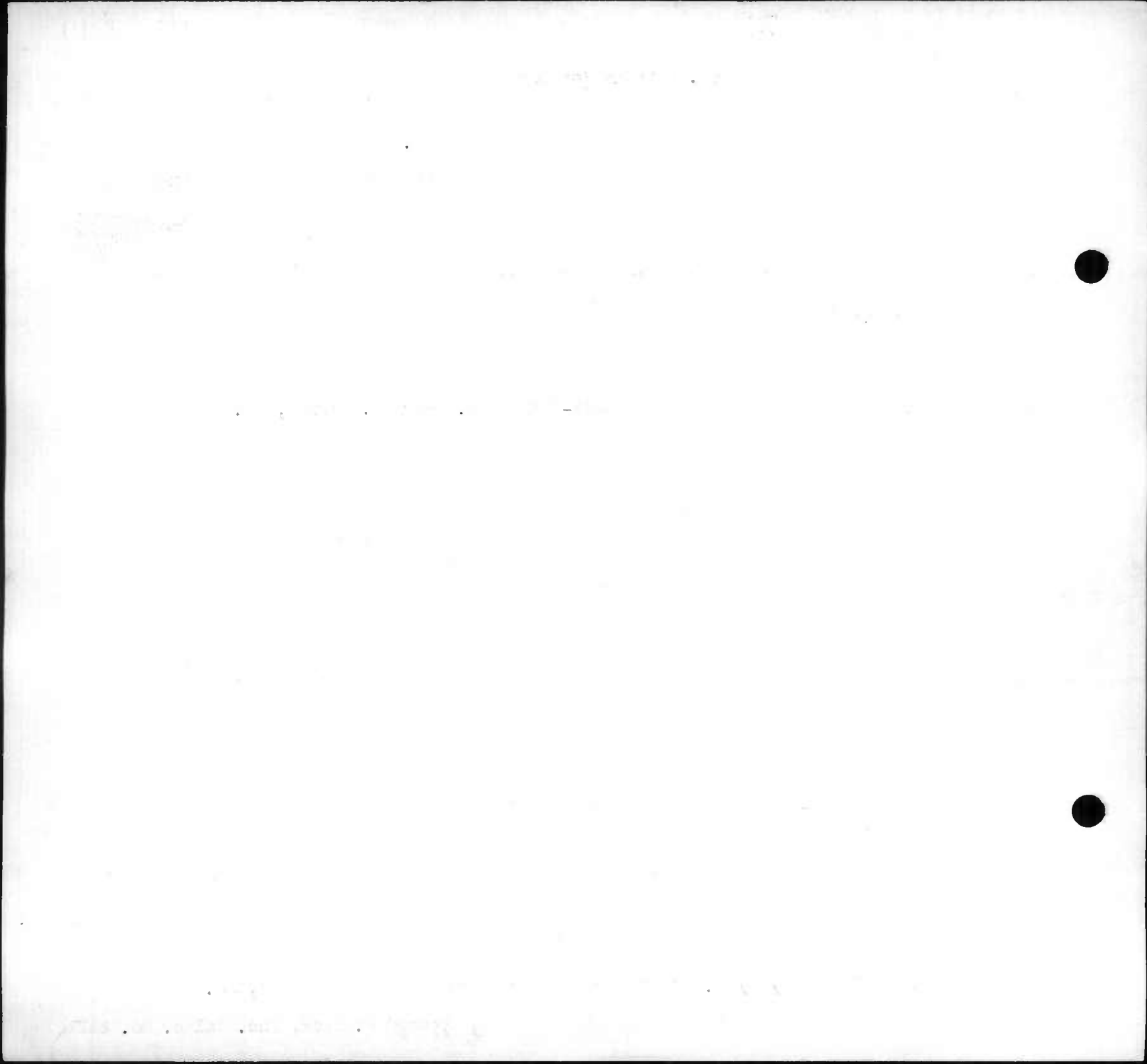
BALTIMORE CITY HEALTH DEPARTMENT				72 00239		REG. NO. 72 00239	
K-610				72 00239			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>KRUBA, WALTER</b>			
2. DATE AND HOUR OF DEATH <b>1-8-72 10:20 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>NORTH CHARLES GEN. HOSPITAL 49</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>3409 Pinewood Ave 2745</b>				5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>1-19-15</b> 9. AGE (In years last birthday) <b>56</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>			
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Kruba</b>				14. MOTHER'S MAIDEN NAME <b>ROSE BRODA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>217-26-1544</b>			
17. INFORMANT <b>Mrs Florence Kruba</b>				ADDRESS <b>Same</b>			
18. <b>5-93-21</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Septic emboli</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Renal shunt down, SBE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/5</b> 19 <b>72</b> to <b>1/8</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>1/8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Veena Sathirakul M.D.</b>				23B. DATE SIGNED <b>1/8/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>VEENA SATHIRAKUL, M.D.</b>				23D. ADDRESS <b>NORTH CHARLES GEN HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/11/72</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>				25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>			
25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore, Md</b>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

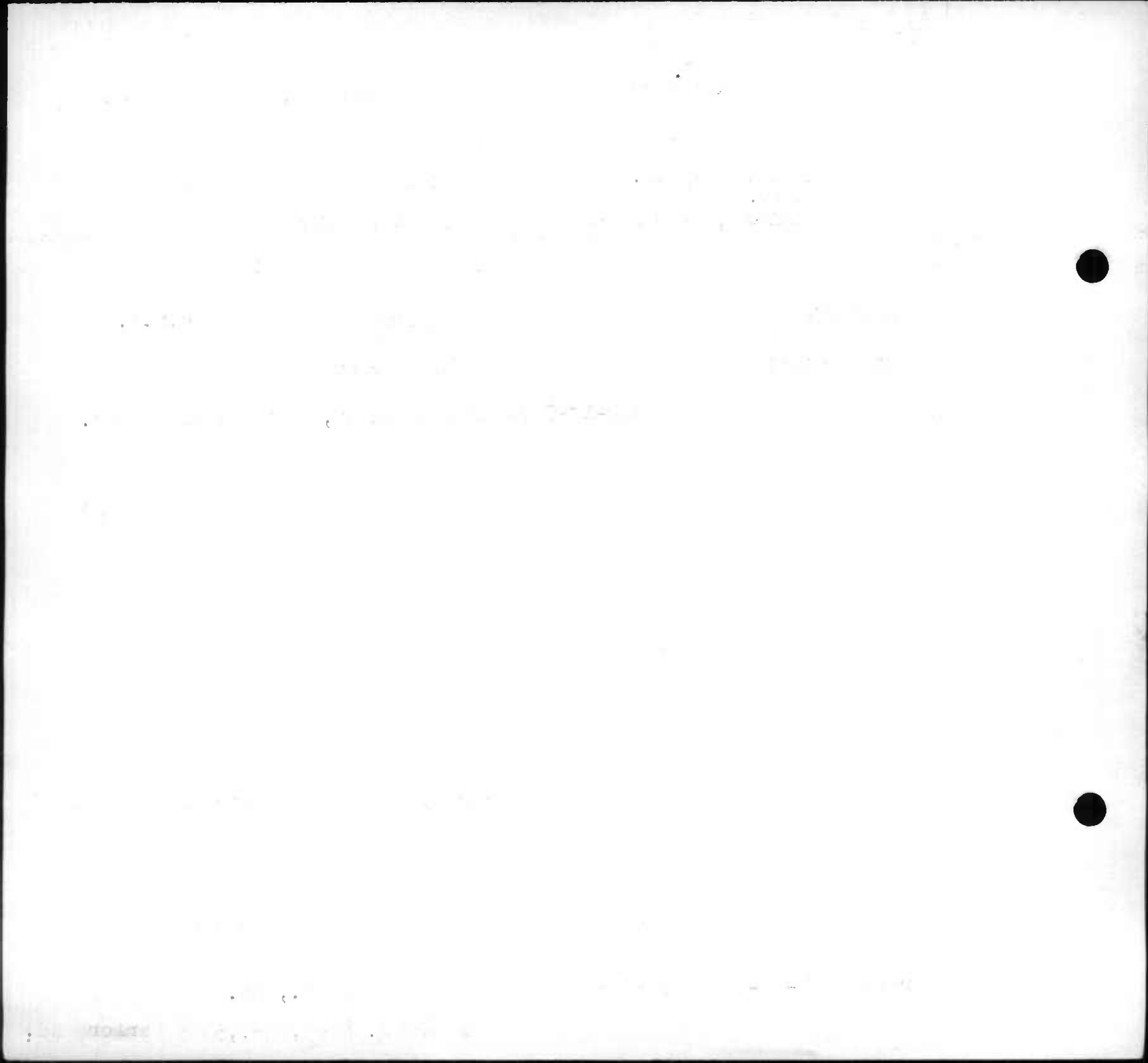
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Voelker Mrs. Dorothy E.		JAN. 8 - 72		5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital		A. STATE Md.		B. COUNTY 2633	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
34		E. STREET AND NUMBER 3429 Dudley Ave.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/02/08	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Smd.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Geo. K. Waldhauser		14. MOTHER'S MAIDEN NAME Mary F. Schwarz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-8732		17. INFORMANT Mr. Henry J. Voelker, Sr.	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CANCER - UREMIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12 - 16 19 71 to 1 - 8 19 72 that (I) (we) last saw the deceased alive on 1 - 8 - 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marco Florez M.D.		23B. DATE SIGNED 1 - 8 - 72			
23C. PHYSICIAN'S NAME (Type) MARCO FLOREZ		23D. ADDRESS 2025W FAYETTE ST			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/12/72		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 11 1972		25B. NAME OF REGISTRAR Leonard G. Ruck, Inc.		25C. FUNERAL DIRECTOR Leonard G. Ruck, Inc. Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-635 72 00241		BALTIMORE CITY HEALTH DEPARTMENT		72 00241	
BIRTH NO.		F.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Catherine NORTON		2. DATE AND HOUR OF DEATH January 9, 1972 3:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202		B. COUNTY		805	
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/12/86		9. AGE (In years last birthday) 85		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Frecker		14. MOTHER'S MAIDEN NAME Minnie Grau	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-18-7372		17. INFORMANT Mildred Ammon, 2909 Linganore Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 17250.9 Terminal Bilateral Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V. Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 25 1967 to January 9 1972 that (I) (we) last saw the deceased alive on Jan. 8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Baum		23B. DATE SIGNED 1/10/72			
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BAUM		23D. ADDRESS 1115 N. CALVERT ST			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-12-72		24C. NAME OF CEMETERY or CREMATORY Baltimore	
24D. LOCATION Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 11 1972		24F. NAME OF REGISTRAR Leonard J. Ruck, Inc., 5305 Harford Rd.	
24G. DATE REC'D BY HEALTH DEPT. JAN 11 1972		24H. NAME OF REGISTRAR Leonard J. Ruck, Inc., 5305 Harford Rd.		24I. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.	

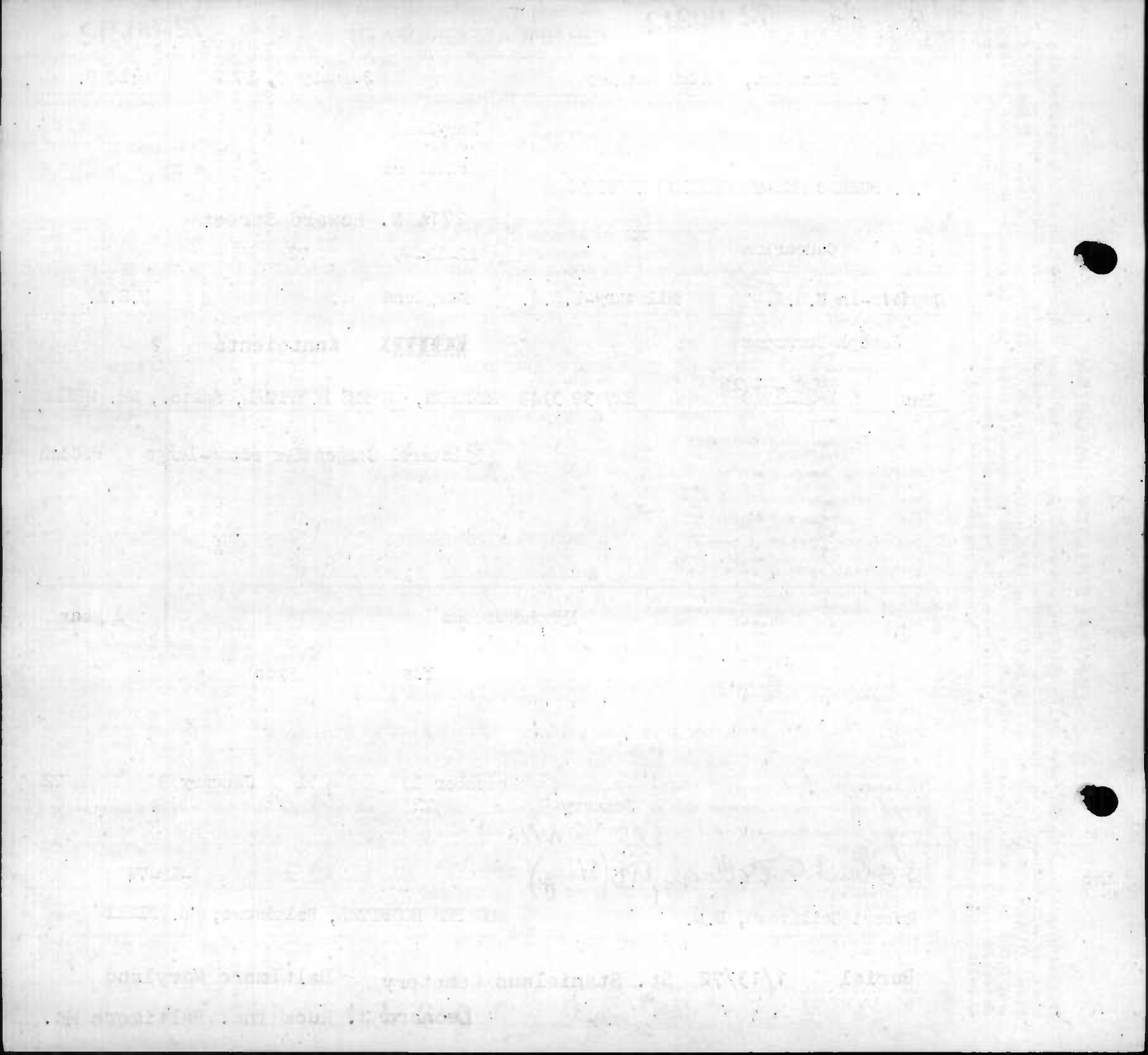




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00212</u>	
B-653 72 00212				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Burnotes, Walter Anthony</u>		2. DATE AND HOUR OF DEATH <u>January 9, 1972</u> <u>6:10 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1206</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. PUBLIC HEALTH SERVICE HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2714 N. Howard Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasion</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-99</u>	9. AGE (In years last birthday) <u>72</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Captain-in U.S.A.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Military-U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Burnotes</u>		14. MOTHER'S MAIDEN NAME <u>ANNTOIENTA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> <u>1918-1918</u> <u>1921-1948</u>		16. SOCIAL SECURITY NO. <u>217 30 3349</u>		17. INFORMANT ADDRESS <u>RECORDS, US PHS HOSPITAL, Balto., Md. 21211</u>	
18. CAUSE OF DEATH <u>200.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Lymphosarcoma</u>		A. IMMEDIATE CAUSE BILATERAL CONGESTIVE EDEMA-LUNGS DUE TO, OR AS A CONSEQUENCE OF: <u>sudden</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Yes</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>December 10</u> 19 <u>71</u> to <u>January 9</u> 19 <u>72</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>January 9</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Robert E. Belliveau, MD (Surgeon)</u>				23B. DATE SIGNED <u>1-10-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert Belliveau, M.D.</u>				23D. ADDRESS <u>US PHS HOSPITAL, Baltimore, Md. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/13/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u>	
24D. LOCATION <u>Baltimore Maryland</u>		24E. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u>		24F. ADDRESS <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Belliveau</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-243 72 00243				72 00243	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>WALTER BEUCHELT</b>			2. DATE AND HOUR OF DEATH <b>1-7-72 5.10 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION: <b>37 MERCY HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE: <b>Maryland</b> B. COUNTY: <b>908</b> C. CITY OR TOWN: <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: <b>605 Cokesbury Ave</b>		
5. SEX <b>M</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1889</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Secretary To Mayor, Balto.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>F. Ernest Buchelt</b>			14. MOTHER'S MAIDEN NAME <b>Anna ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>			16. SOCIAL SECURITY NO. <b>214-40-7191</b>		17. INFORMANT <b>Mrs Lurline H Beuchelt</b> ADDRESS: <b>Same</b>
18. <b>412.3 142509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Septicemia with Endocarditis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Septicemia with Endocarditis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic heart disease</b> (C) <b>Diabetes mellitus</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <b>1-5-72</b> to <b>1-7-72</b> 19 <b>72</b> that (B) (we) last saw the deceased alive on <b>1-7-72</b> 19 <b>72</b> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Shawkin Malek</b> DEGREE				23B. DATE SIGNED <b>1/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Shawkin Malek</b> DEGREE				23D. ADDRESS <b>Mercy Hosp Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/11/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>			
25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore, Md</b>			

///

603 Locksberry Ave  
Aug. 23, 1939

Assistant Secretary to Mayor  
Anna

214-40-1114 Mrs. Caroline H. Gausche  
Sam

BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO.

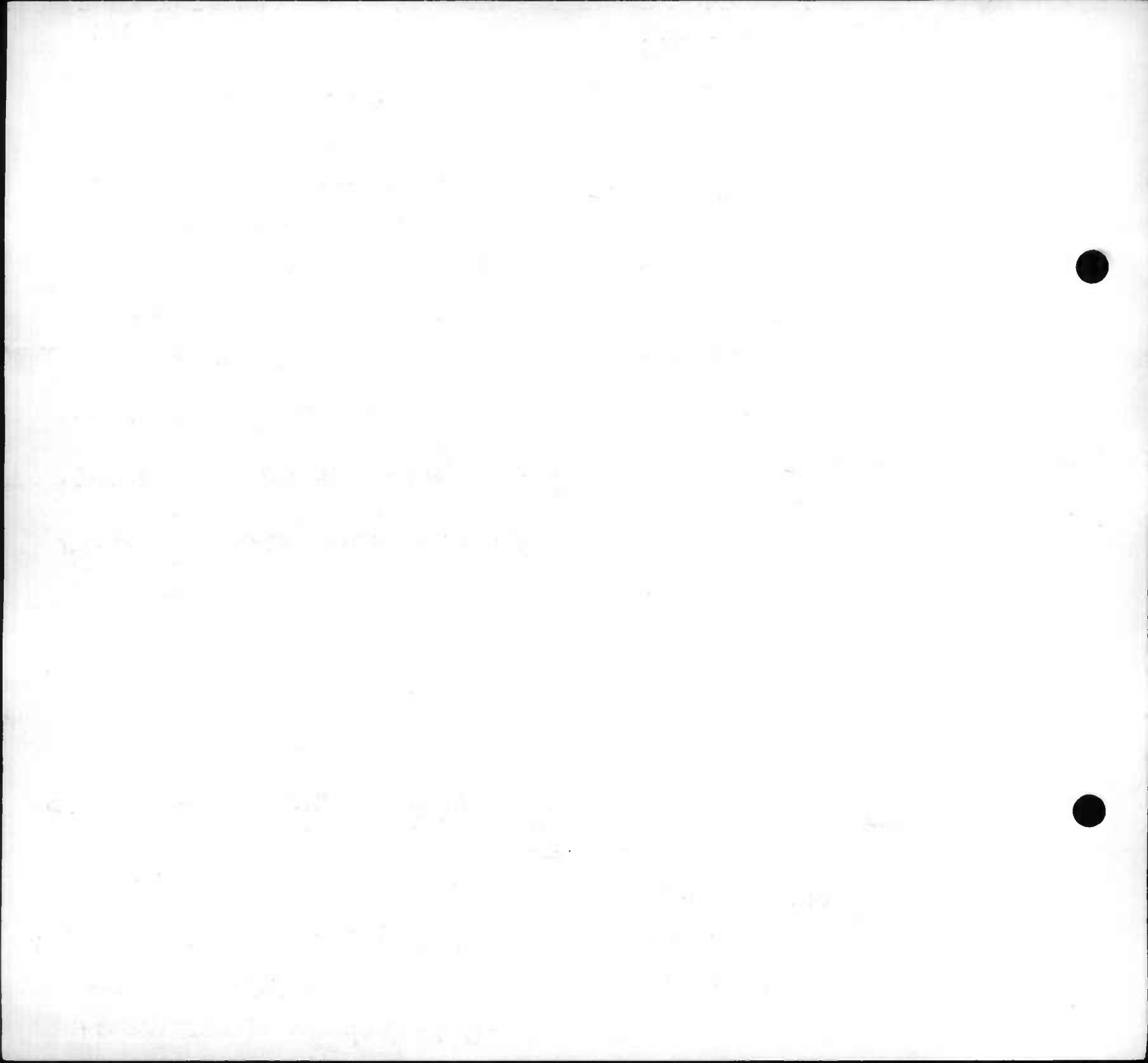
1. NAME OF DECEASED (Type or Print) <b>CHARLIE R. GREENE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>January 8, 1972</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 8, 1972 2:00 A</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>3210 McEldery St.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2610</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>2/4/1917</b>	10. AGE (In years last birthday) <b>54</b>	11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Greene</b>		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Glen Co.</b>	
15. MOTHER'S MAIDEN NAME <b>Carrie Higgs</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>?</b>	
18. INFORMANT <b>Bertha V. Burrell</b>		19. CAUSE OF DEATH <b>1959 I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Malignant neoplasm involving neck</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>1959</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>buried</b>		24B. DATE <b>1/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>John J. Conway, Jr. Inc.</b>	
25C. FUNERAL DIRECTOR <b>John J. Conway, Jr. Inc.</b>		25D. ADDRESS <b>901 Hollins St.</b>		25E. ADDRESS <b>Baeth - Md. 21223</b>	

ACADEMIC



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 72 00215	
K-223 72 00215				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA KOZOJET				2. DATE AND HOUR OF DEATH JAN. 5, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 HOOD NURSING HOME				A. STATE MD. B. COUNTY BALTIMORE 5300			
				C. CITY OR TOWN CATONSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 5 N. BEAUMONT AVE.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 15, 1885	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME — HAVLIK				14. MOTHER'S MAIDEN NAME — SCHIMUNEK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. C. Frank Witte - 5 Beaumont Ave.		ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest		minutes	
ANTECEDENT CAUSES				(B) Coronary thrombosis		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 1972 to Jan 5 1972 that (I) last saw the deceased alive on 1/4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James J. Nolan				23B. DATE SIGNED 1/7/72			
23C. PHYSICIAN'S NAME (Type) SJ NOLAN				23D. ADDRESS 1 Mallow Hill Rd Baltimore Md 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-8-72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Conv.		24D. LOCATION (City, town, or county) Baltimore Ind.	
25A. DATE REC'D. BY HEALTH DEPT. JAN 11 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS	

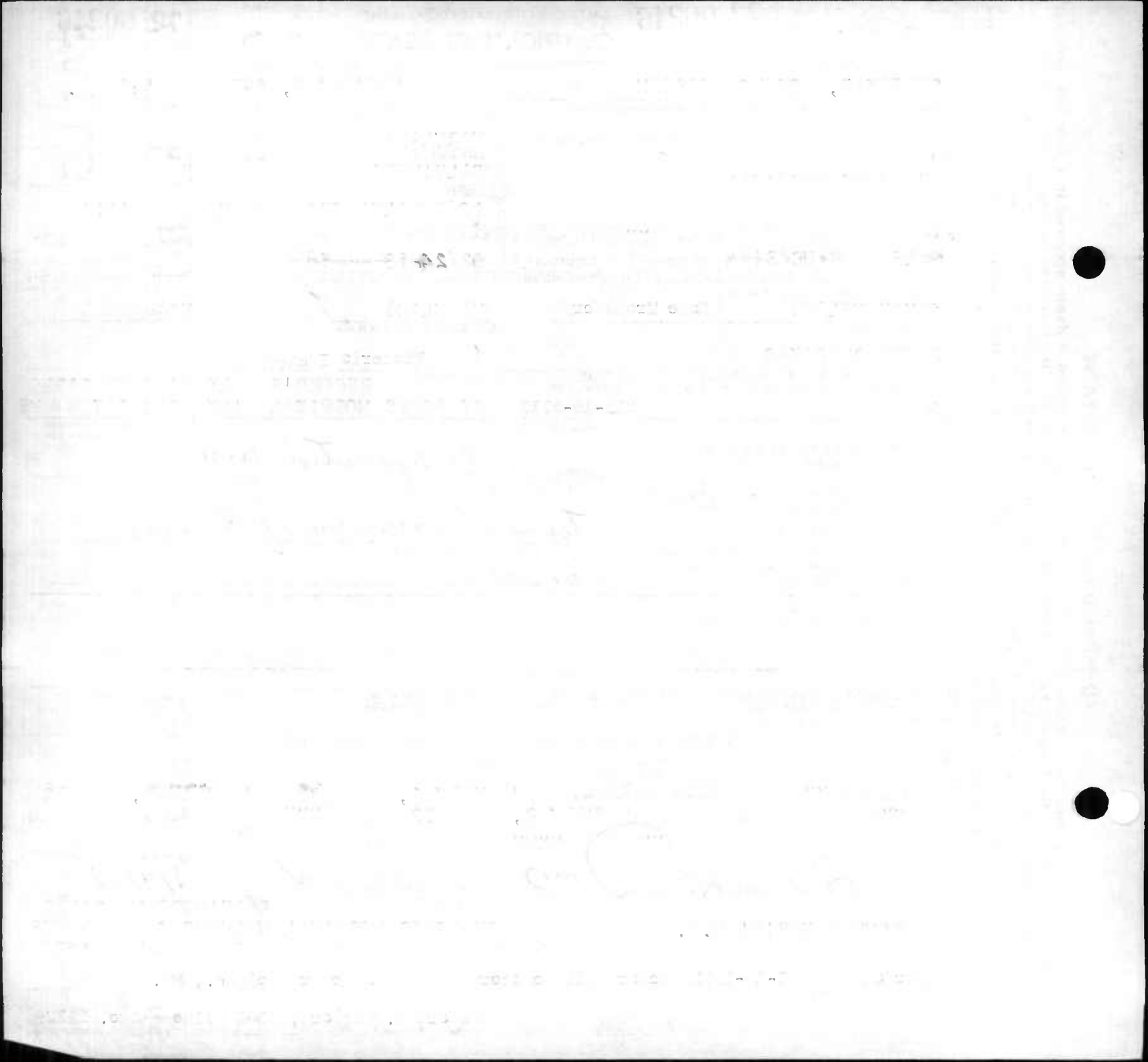




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

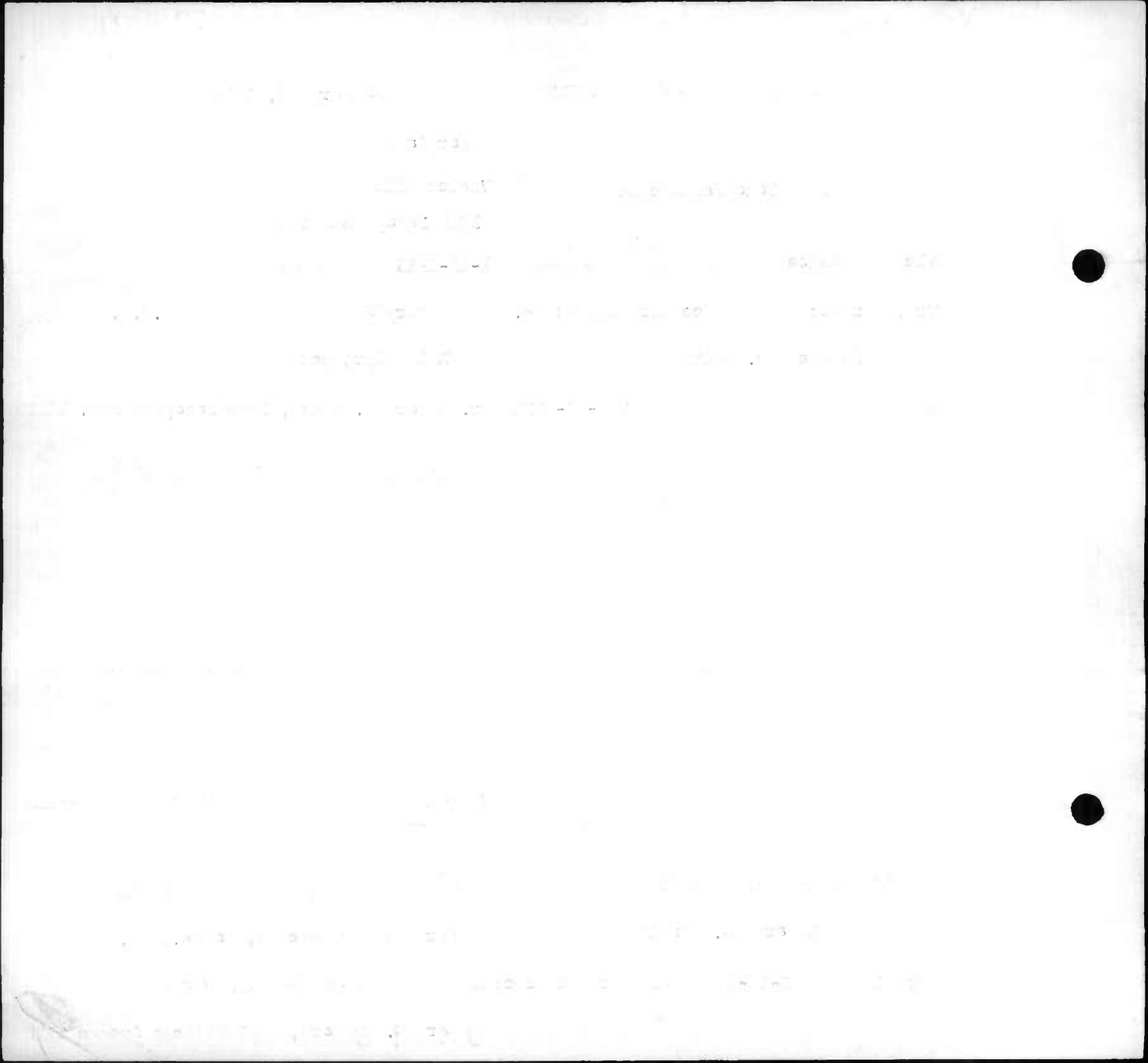
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00246</span>	
S-122				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SHAPOKAS, GEORGE JOSEPH</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 7, 1972 4:15 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <b>40</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>2582</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1067 WILMINGTON AVENUE 21223</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02/24/13</b>	9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK HELPER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Kane Transfer</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PETER SHAPOKAS</b>			
14. MOTHER'S MAIDEN NAME <b>( Victoria Inchowska</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>215-14-8717</b>		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b> <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Dehydration and</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <b>Terminal Carcinoma of Rectum</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>Bronchitis</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>JANUARY 3, 19 72</b> to <b>JANUARY 7, 19 72</b> that <del>XX</del> (we) last saw the deceased alive on <b>JANUARY 7, 19 72</b> and that <del>XX</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) (did) (do) <del>XX</del> view the body after death.					
23A. SIGNATURE <b>Rahman Karimi M.D.</b>				23B. DATE SIGNED <b>1/7/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAHMAN KARIMI M.D.</b>				23D. ADDRESS <b>BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-10-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION <b>Anne Arundel Co., Md.</b>		25A. DATE RECD BY HEALTH DEPT. <b>JAN 11 1972</b>			
25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00247</u>	
BIRTH NO. <u>8-530</u>		72 00247			
1. NAME OF DECEASED (Type or Print) <b>EDWARD NORMAN SMITH</b>			2. DATE AND HOUR OF DEATH <b>January 7, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>3805 Patapsco Avenue</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2551</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3805 Patapsco Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1911</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Keebler Biscuit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jessie N. Smith</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-07-0231</b>		17. INFORMANT <b>Mr. Edward W. Smith, 3805 Patapsco Ave. 21229</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>I</b> <b>Carcinoma of Rectum</b> <b>5 yrs</b> <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>1/4/72</b> 19 to <b>1/7/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/6</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Edward S. Kallins</b> DEGREE 23B. DATE SIGNED <b>1/7/72</b> 23C. PHYSICIAN'S NAME (Type) <b>Edward S. Kallins</b> DEGREE 23D. ADDRESS <b>6000 Park Heights Avenue, Balto., Md.</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1-10-1972</b> 24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b> 25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b> 25C. FUNERAL DIRECTOR ADDRESS <b>4107 Wilkens Avenue 21229</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00248	
BIRTH NO. 3-655		72 00248	
1. NAME OF DECEASED (Type or Print) <b>ALBERT E. GERMAN</b>		2. DATE AND HOUR OF DEATH <b>1/8/72 9:25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 BON SECOURS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b> C. CITY OR TOWN <b>ELLICOTT CITY</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3997 OLD COLUMBIA PIKE</b>	
5. SEX <b>MALE</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/5/1900</b> 9. AGE (in years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>
13. FATHER'S NAME <b>JOSEPH GERMAN</b>		14. MOTHER'S MAIDEN NAME <b>FELECIE BURNO</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-19-9795</b>	
18. <b>4-12-31</b>		17. INFORMANT <b>Margaret German</b> ADDRESS <b>3997 Columbia Rd. Ellicott City, Md 21043</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Coronary insufficiency Generalized arterio-sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Acidosis</b> <b>Cirrhosis of liver</b> <b>Severe anemia, Anuria, Chronic Nephrosclerosis</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Inally medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-8-72</b> 19 to <b>1-8-72</b> 19 that (I) (we) last saw the deceased alive on <b>1-8-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Yunyong Yunyongying</b>		23B. DATE SIGNED <b>1-8-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>YUNYONG YUNYONGYING</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-12-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Crest Lawn Gardens</b>	24D. LOCATION (City, town, or county) (State) <b>ELLICOTT CITY MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Black Funeral Home</b>	ADDRESS <b>Ellis &amp; City and 21043</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00249	
M-610 72 00249				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>EDNA MURPHY</b>			2. DATE AND HOUR OF DEATH <b>1-9-72</b> <b>1:16 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2404</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CERTIFICATE AMENDED</b> <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1631 Webster St.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-11-94</b>	9. AGE (in years last birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>			13. FATHER'S NAME <b>ERNEST AIGRY</b>		
14. MOTHER'S MAIDEN NAME <b>MARGERET GORMAN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>unknown</b>			17. (INFORMANT) <b>Margaret E. West</b> ADDRESS <b>1631 Webster Street Balto.</b>		
18. <b>156.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CARCINOMA OF GALL BLADDER</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-9-72</b> 19 <b>1-9-72</b> to <b>1-9-72</b> 19 <b>1-9-72</b> that (I) (we) last saw the deceased alive on <b>1-9-72</b> 19 <b>1-9-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edith H. H. H.</b>				23B. DATE SIGNED <b>1-9-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edith H. H. H.</b>				23D. ADDRESS <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/12/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. CITY, TOWN, OR COUNTY (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>Edith H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Mc Cully Funeral Homes</b> ADDRESS <b>130 E. Fort Ave.</b>	

2-2-1972 - Correction Form from Funeral Director (also: Letter from South Baltimore General Hospital, Melva G. Kellenbenz, Medical Records Administrator & Verification of Baptismal Record of the Good Shepherd United Methodist Church.-baptism -June 25, 1916.) HRS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420		72 00250		BALTIMORE CITY HEALTH DEPARTMENT		X		72 00250	
CERTIFICATE OF DEATH				REG. NO.					
1. NAME OF DECEASED (Type or Print) <b>EDNA SMITH BLACK</b>				2. DATE AND HOUR OF DEATH <b>1/5/72</b> <b>8<sup>30</sup> A</b> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A. A. CO.</b> <b>5200</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>1-17-72</b>				C. CITY OR TOWN <b>ARNOLD</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <b>805 BRADFORD AVE.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-2-19</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Health Department</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOUSTON A. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>OLGA Paulson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>171-16-7498</b>		17. INFORMANT <b>H. 53 Northmont St. 15601</b> <b>Walter Smith</b> <b>Glennview Ave. Greensburg, Pa.</b>			
18. <b>394.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Ventricular tachycardia</b> <b>10 min</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Rheumatic Heart Disease MS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>and MI</b> <b>7 yrs</b>					
				(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> <b>19 72</b> to <b>1/5</b> <b>19 72</b> that (I) (we) last saw the deceased alive on <b>1/5</b> <b>19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>James Franklin Grim</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/5/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>James Franklin Grim</b>				23D. ADDRESS <b>1528 McElderry St.</b>		<b>Balt. 21208</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN. 8, 72</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenwood Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>New Kensington West Pennsylvania</b>		24E. MORELAND CO.	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Road 21133</b>			

1-17-1972 - Correction form from Funeral Director.

HRS

A  
M

YES ☒ NO ☐

5360 SINCLAIR LANE 21206

12. CITIZEN OF WHAT COUNTRY	
-----------------------------	--

14. MOTHER'S MAIDEN NAME

ADDRESS \_\_\_\_\_

3104 GLENMORE AVE  
BIRMINGHAM, ALA 35214

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## Pulmonary edema

(b) CONGESTIVE HEART FAILURE  
DUE TO, OR AS A CONSEQUENCE OF:  
(c) ARTERIOSCLECTIC DISEASE

20B. IF YES, WERE FINDINGS CONSIDERED

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-20-71 1971 to 1-6 1972  
that (I) (we) last saw the deceased alive on 1-6-72 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23B. DATE SIGNED

СМ 14 -

(State)

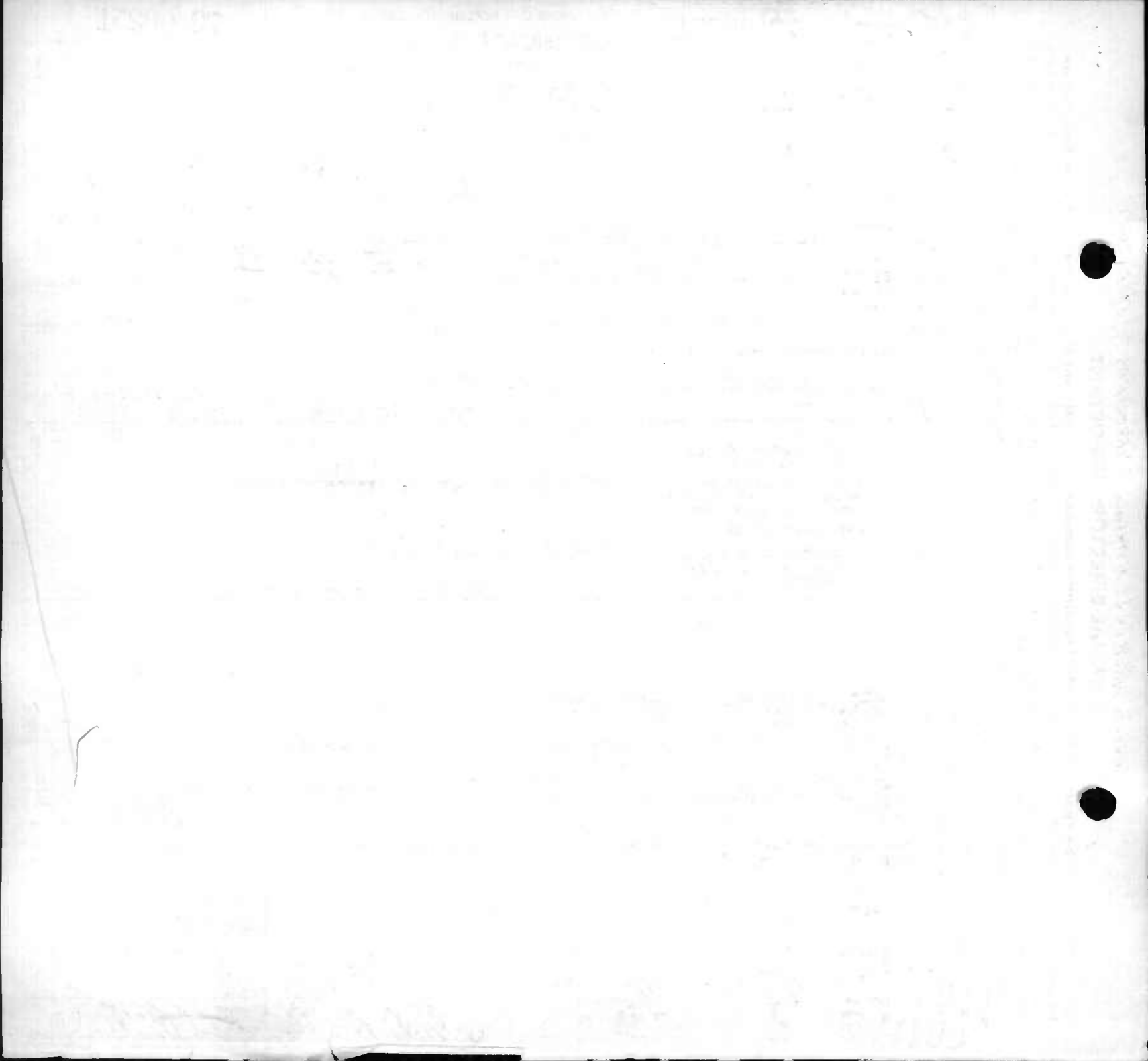
Bo. To

ADDRESS

250. FEDERAL DIRECTOR

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. Such

## FUNERAL DIRECTOR: IMPORTANT



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GASTON ASHLEY, JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>January 8, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2350 Fredrick Avenue (Tavern)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 8, 1972</b> 10:10 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>	
9. DATE OF BIRTH <b>5-10-47</b>		10. AGE (In years last birthday) <b>24</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gaston Ashley Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Marie Robinson</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. <b>E 9651</b>		20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
21. DATE OF OPERATION <b>2</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Tavern</b>	
25. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1-8-72 10:00 P.m.</b>		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
27. WHERE DID INJURY OCCUR? <b>2350 Fredrick Avenue</b>		28. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		DATE SIGNED <b>January 9, 1972</b>	
30. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		31. DATE <b>1-16-72</b>	
32. NAME OF CEMETERY or CREMATORY <b>Fayetteville, N.C.</b>		33. LOCATION (City, town, or county) (State)	
34. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		35. NAME OF REGISTRAR <b>Wm C March</b>	
36. FUNERAL DIRECTOR <b>928 E North Ave.</b>		37. ADDRESS	

50000

50000

ACADEMY OF

VALLEY PARK

RAM COUNTY

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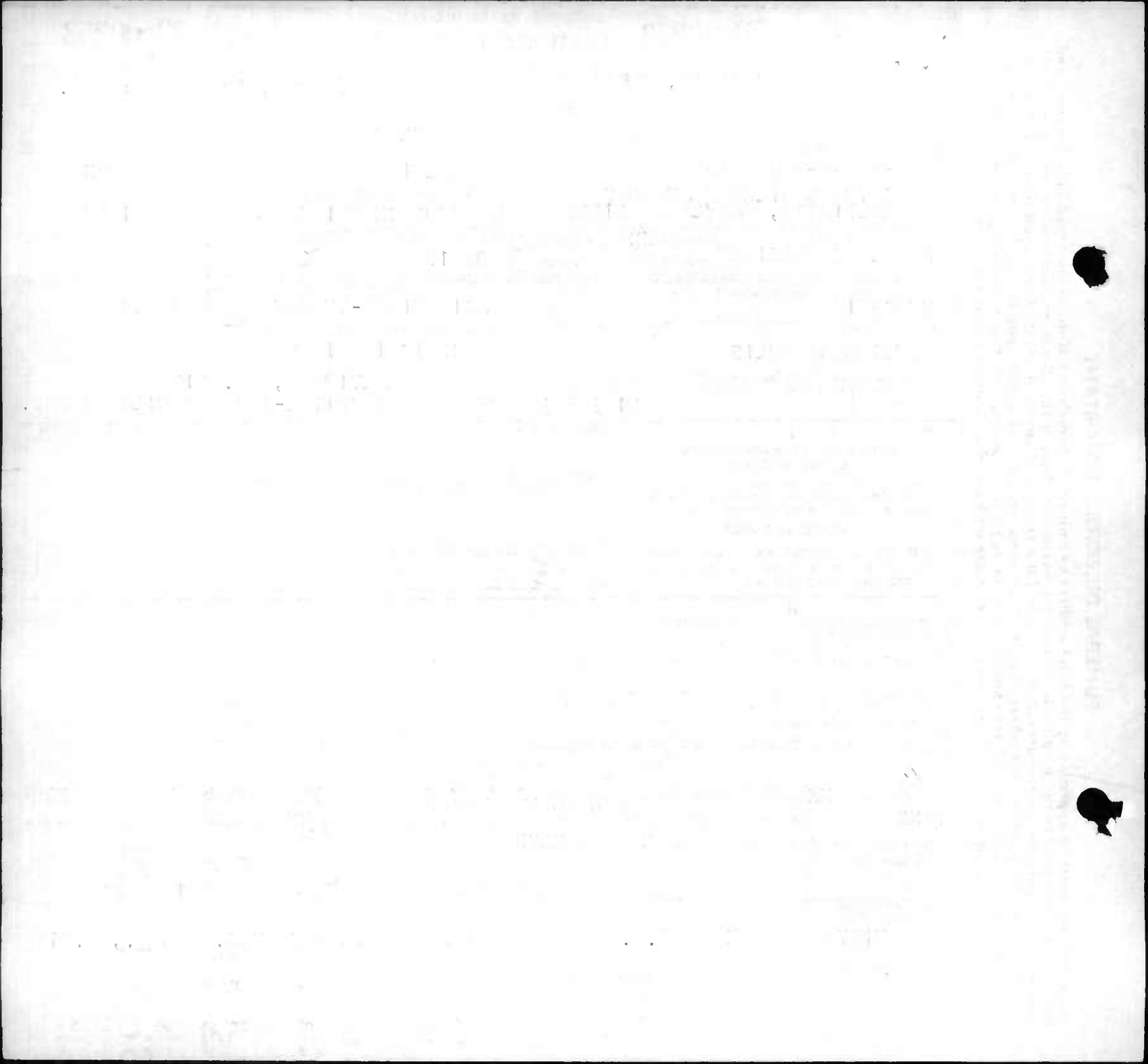
ON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00253	
BIRTH NO. <u>K-612</u>		72 00253					
1. NAME OF DECEASED (Type or Print) <u>KARAVASILIS, STELIANE</u>				2. DATE AND HOUR OF DEATH <u>JANUARY 9, 1972</u> <u>4:50 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>CATON &amp; WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5502 CHANNING ROAD</u> <u>21229</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06 10 89</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ASIA MINOR-TURKEY</u>		
12. CITIZEN OF WHAT COUNTRY? <u>GREECE</u>			13. FATHER'S NAME <u>JAMES HONDROULIS</u>				
14. MOTHER'S MAIDEN NAME <u>CHRISIE DIMON</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>219387738</u>			17. INFORMANT <u>BALTIMORE, MD. 21229</u> ADDRESS <u>ST AGNES HOSPITAL-CATON &amp; WILKENS AVE.</u>				
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>XIX</u> (this hospital) attended the deceased from <u>JANUARY 5</u> 19 <u>72</u> to <u>JANUARY 9</u> 19 <u>72</u> that <u>(X)</u> (we) lost saw the deceased alive on <u>JANUARY 9</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Benauides</u>				23B. DATE SIGNED <u>01 09 72</u>			
23C. PHYSICIAN'S NAME (Type) <u>VICTOR BENAVIDES M.D.</u>				23D. ADDRESS <u>CATON &amp; WILKENS AVES. BALTO., MD. 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/12/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greek Orthodox Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robbie J. J. 2 0 0 0</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>		ADDRESS <u>21228</u>	



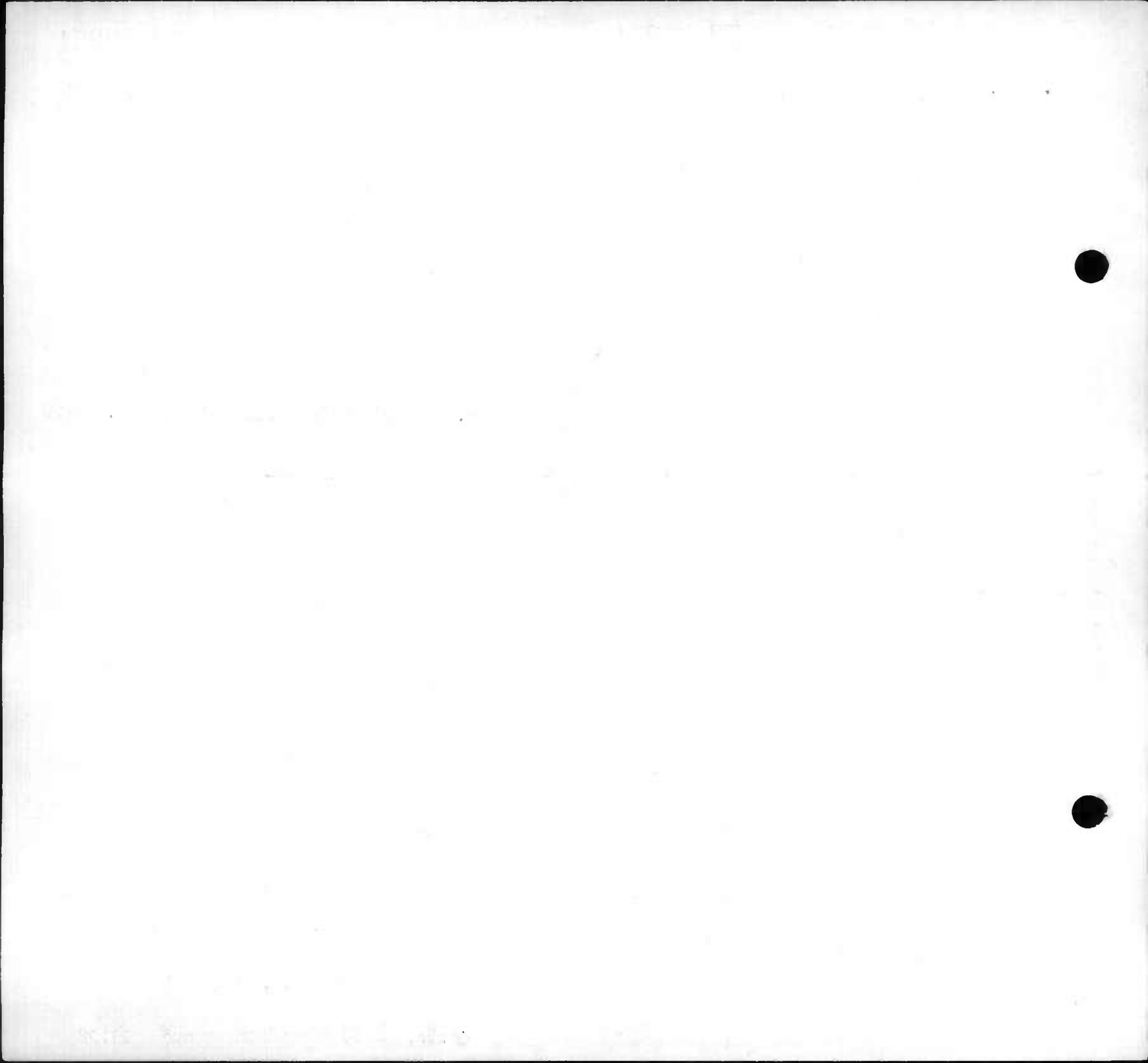




# FUNERAL DIRECTOR: IMPORTANT

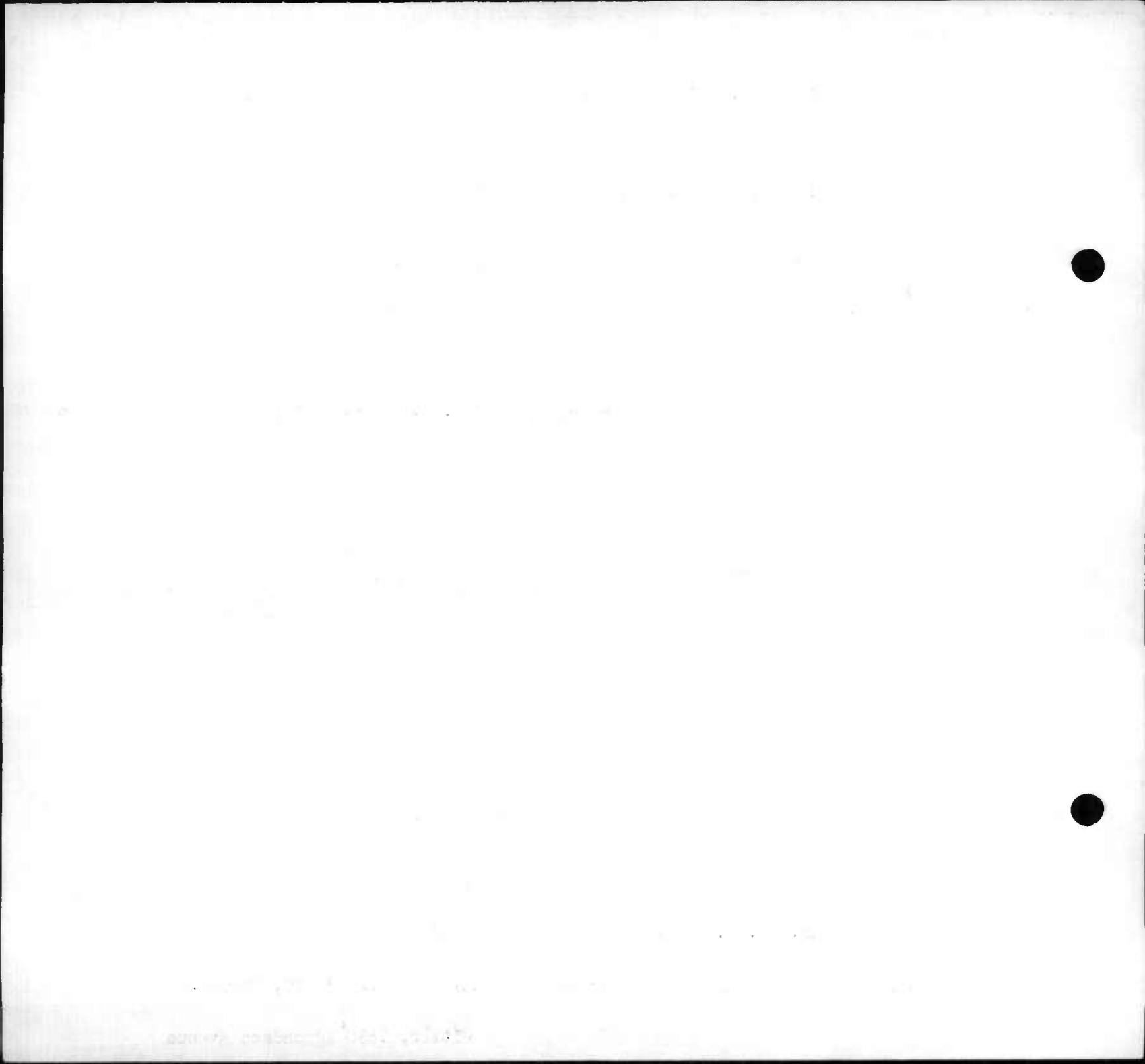
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00254</u>	
BIRTH NO. <u>W-420</u>					
1. NAME OF DECEASED (Type or Print) <u>WELLS EDNA</u>			2. DATE AND HOUR OF DEATH <u>1-9-72</u> <u>10 50 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>			A. STATE <u>Md</u> B. COUNTY <u>Baltimore Co.</u> <u>5300</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>1211 Redcliff Rd.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-17</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Salvatore Guarniera</u> (deceased)		14. MOTHER'S MAIDEN NAME <u>Concetta</u> (deceased)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. Charles Wells 1211 Redcliff Rd. 21228</u>	
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Adenocarcinoma of lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>none</u>					
19A. DATE OF OPERATION <u>none known</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <u>1-6</u> 19 <u>72</u> to <u>1-9</u> 19 <u>72</u> that <del>(X)</del> (we) last saw the deceased alive on <u>1-9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael P. Buchness M.D.</u>				23B. DATE SIGNED <u>1-9-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael P. Buchness</u>				23D. ADDRESS <u>University Hospital.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/13/72</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Witzke, 51630 Edmondson Avenue 21228</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

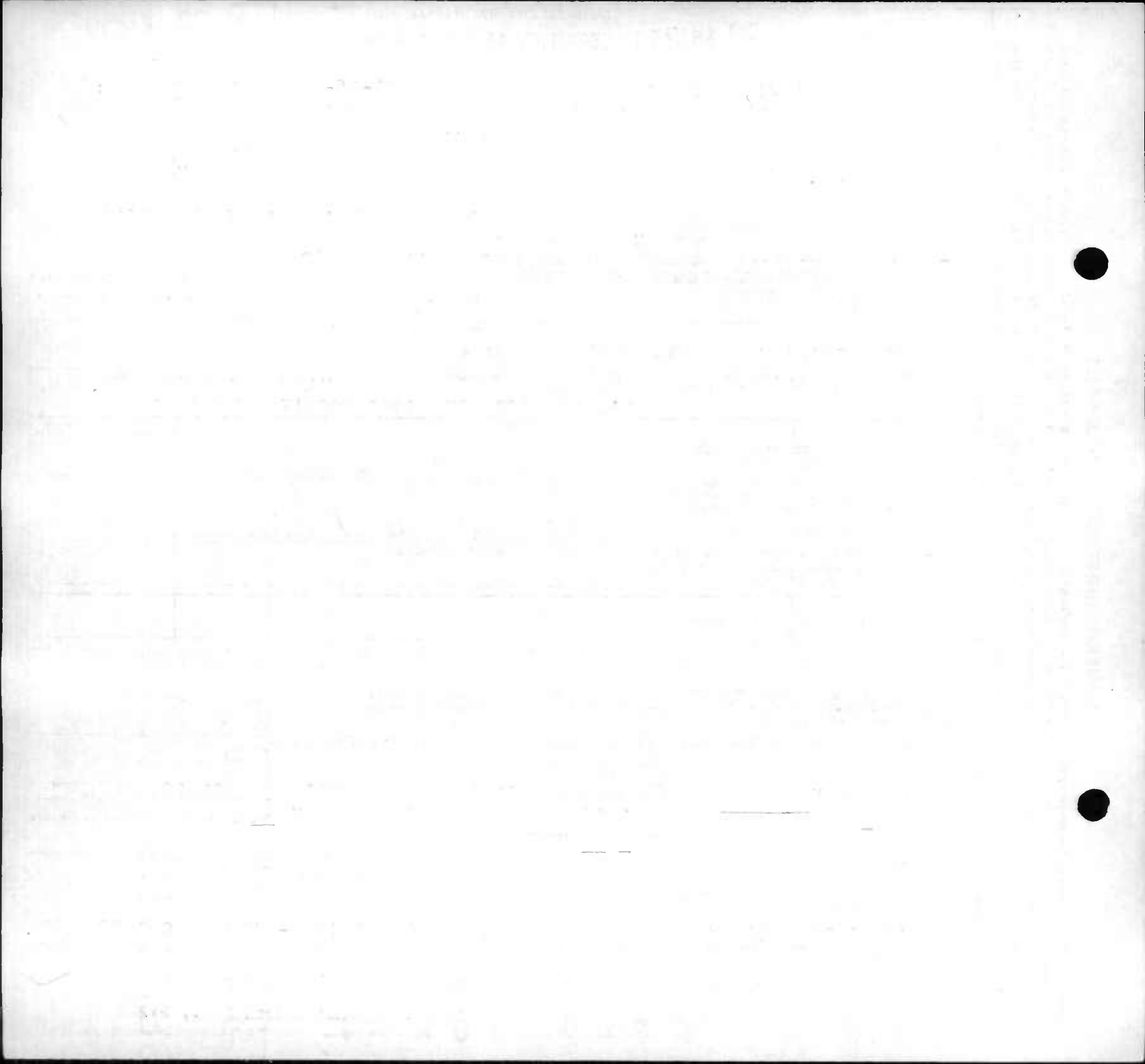
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00255</u>	
<div style="display: flex; justify-content: space-between;"> <span>W-300</span> <span>72 00255</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Myrtle V. White</u>				2. DATE AND HOUR OF DEATH <u>1/8/72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2834</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4929 Westhills Parkway</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4929 Westhills Parkway</u>	
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1894</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <u>Usa</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME		
16. SOCIAL SECURITY NO. <u>578-07-5485D</u>			17. INFORMANT <u>Geo. W. Blankenship, Belmont Acres, Preston MD</u>		
18. <u>4/2.3 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Chronic Bronchitis &amp; Emphysema</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 69</u> to <u>8 Jan 1972</u> that (I) (we) last saw the deceased alive on <u>8 Jan 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William J. Bryson MD</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr. Wm. J. Bryson</u>				23B. DATE SIGNED <u>10 Jan 72</u>	
23D. ADDRESS <u>Westview Mall</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/12/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [illegible]</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

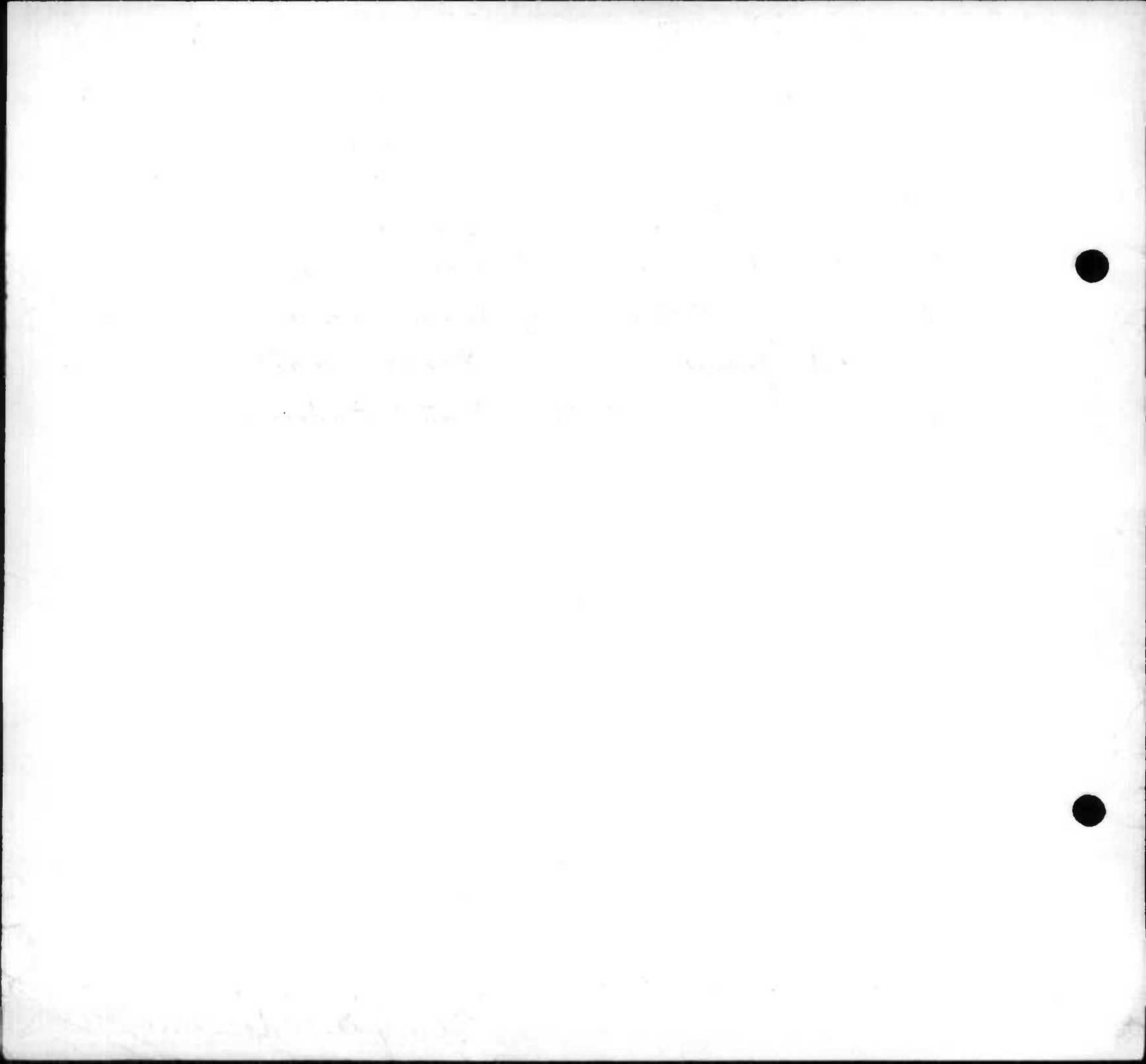
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00256</u>
V-533 72 00256		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>VANDITTI, GRACE ANNA</u>		
2. DATE AND HOUR OF DEATH <u>01-10-72</u> <u>7:00A</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> <u>ST. AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTO</u> B. COUNTY <u>2834</u>		
5. SEX <u>FEMALE</u> 6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>07 09 11</u>		9. AGE (In years last birthday) <u>60</u>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
13. FATHER'S NAME <u>FRANK MASSININO (Massimini)</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216 36 6057</u>		
17. INFORMANT <u>WILKENS &amp; CATON AVE.</u>		ADDRESS <u>ST AGNES HOSPITAL RECORDS</u>		
18. <u>398X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Rheumatic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <u>12 28</u> 19 <u>71</u> to <u>01 10</u> 19 <u>72</u> that (X) (we) last saw the deceased alive on <u>01 10</u> 19 <u>72</u> and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (X) (X) view the body after death.				
23A. SIGNATURE <u>Young Soon Lee M.D.</u> DEGREE		23B. DATE SIGNED <u>January 10, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>YOUNG SOON LEE M D</u> DEGREE
23D. ADDRESS <u>ST AGNES HOSPITAL-WILKENS &amp; CATON AVE.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/13/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

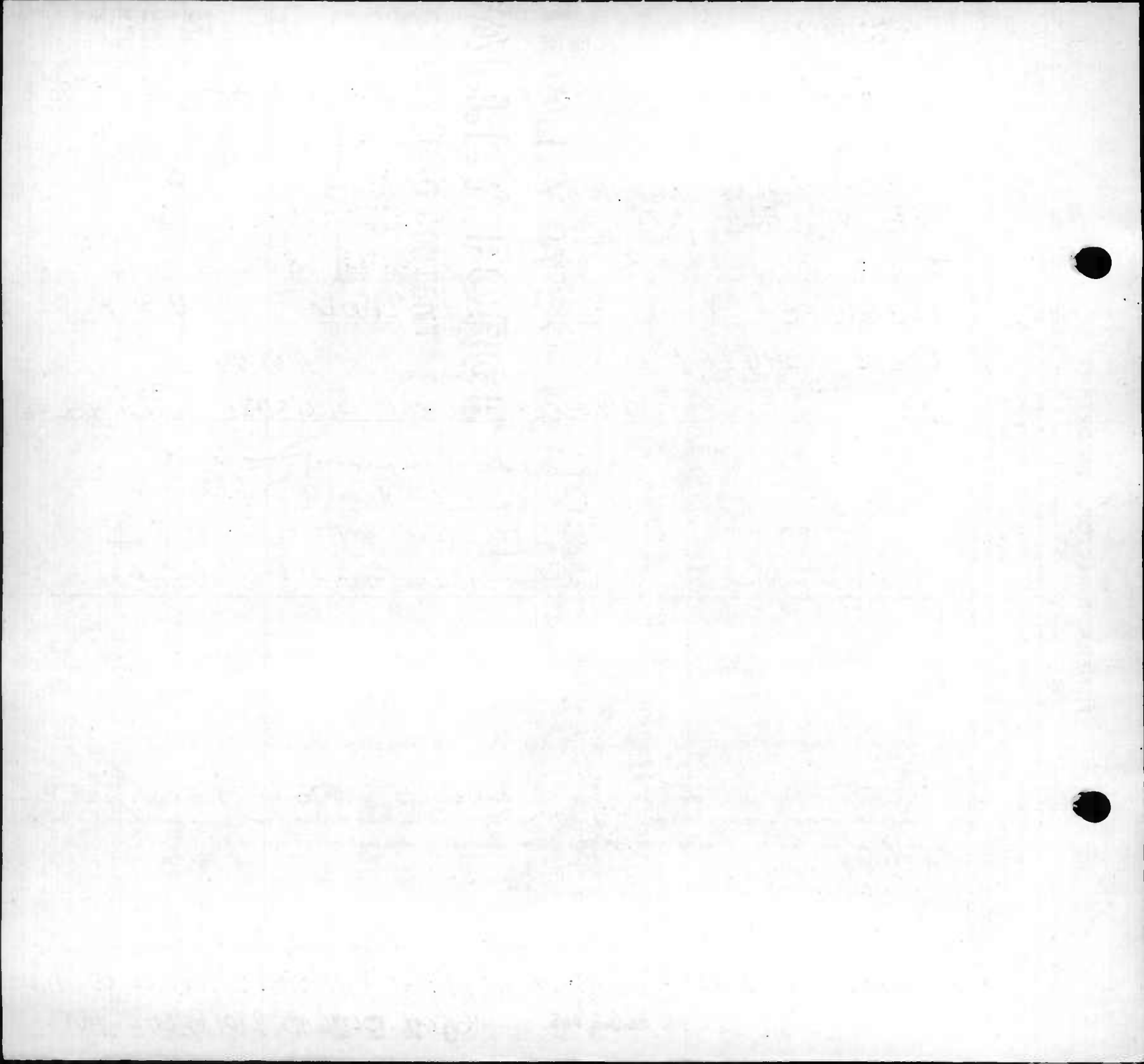
L-200		72 00257		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00257	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Henry Floyd Lewis</u>				2. DATE AND HOUR OF DEATH <u>Jan. 8<sup>th</sup> 1972</u> <u>7 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>939 N. Broadway</u>						A. STATE <u>Maryland</u>		B. COUNTY <u>704</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>939 N. Broadway</u>									
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1903</u>		9. AGE (In years last birthday) <u>68</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Fred Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Many Hall</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-1414</u>		17. INFORMANT <u>Hattie Andrews</u>		ADDRESS <u>- Same</u>			
18. <u>155.01</u> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HEPATOMA</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 11</u> 19 <u>71</u> to <u>Nov 2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Nov 2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Turner Bledsoe MD</u>						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Turner Bledsoe, M.D.</u>						23D. ADDRESS <u>The Johns Hopkins Hospital, Balto, Md. 21205</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>O. Wilson</u>		ADDRESS <u>1000 Brantley Ave</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

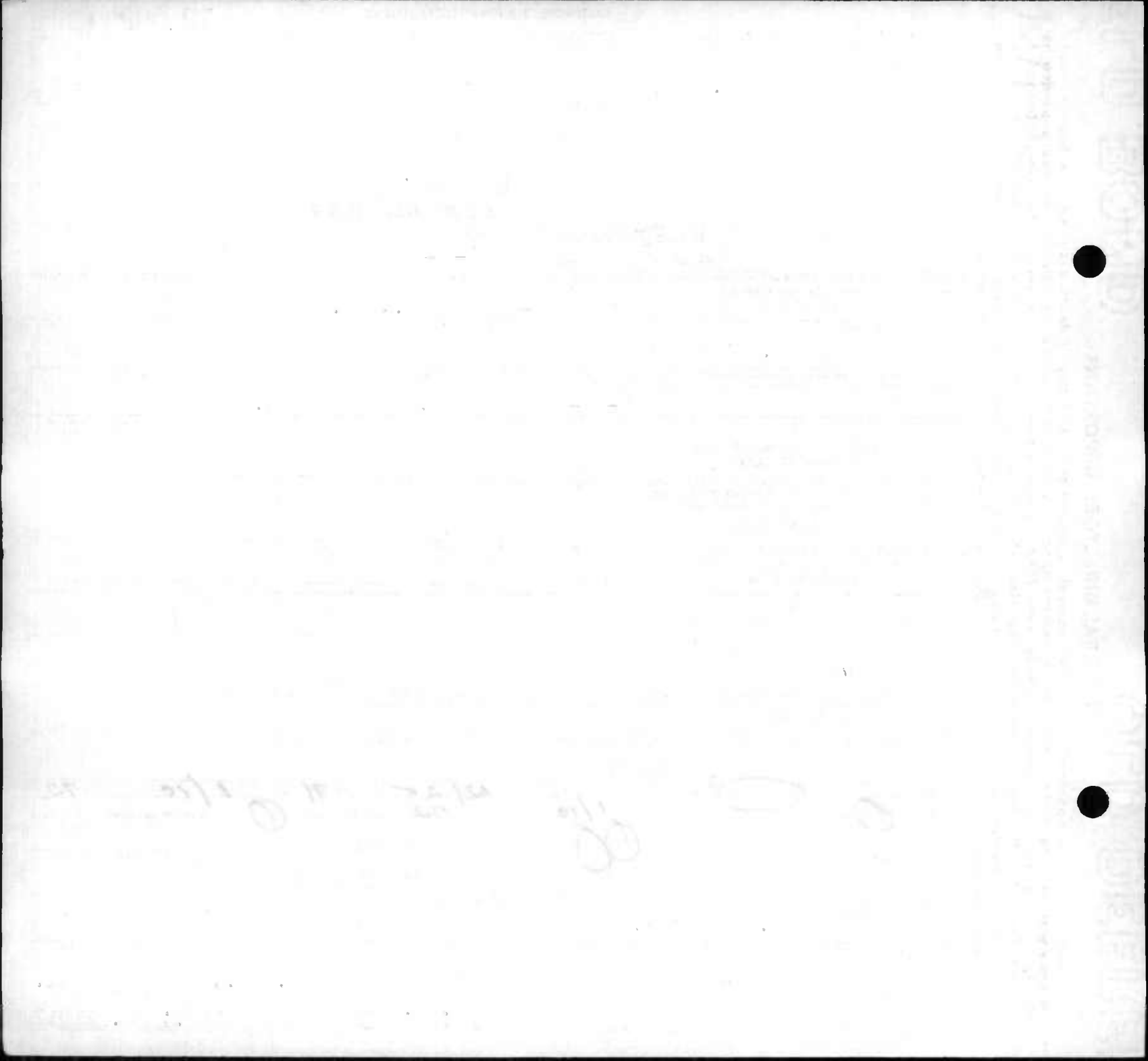
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00258	
72 00258					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSE ELLER STOCKSDALE</b>		2. DATE AND HOUR OF DEATH <b>JAN. 9, 1972 3:30 A.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2005</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 CENTURY NURSING HOME</b> <b>102 N. PACA ST.</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>FEMALE</b> 6. RACE <b>CAU</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 30, 1883</b> 9. AGE (In years last birthday) <b>88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>REESE SHIPLEY</b>		
14. MOTHER'S MAIDEN NAME <b>MORAN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>219105568</b>			17. INFORMANT <b>HOWARD M. STOCKSDALE</b> ADDRESS <b>3570 BENZINGER RD.</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Respiratory Failure</b> <b>Eng. Due Heart Failure</b> <b>Anteroselective C.U.H.D.</b> <b>Gen. &amp; Cor. Blood Anteroselective</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Similarity</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 8 1970</b> to <b>JAN 9 1972</b> that (I) (we) lost saw the deceased alive on <b>JAN 9 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>Willard Appleford</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Willard Appleford</b>				23D. ADDRESS <b>6615 New Terston Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-12-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>FINKSBURG METHODIST FINKSBURG, CARROLL CO. MD.</b>	
24D. LOCATION (City, town, or county) (State) <b>FINKSBURG, CARROLL CO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>GEORGE SCHWAB</b>		25D. ADDRESS <b>2101 FRED'K AVE.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

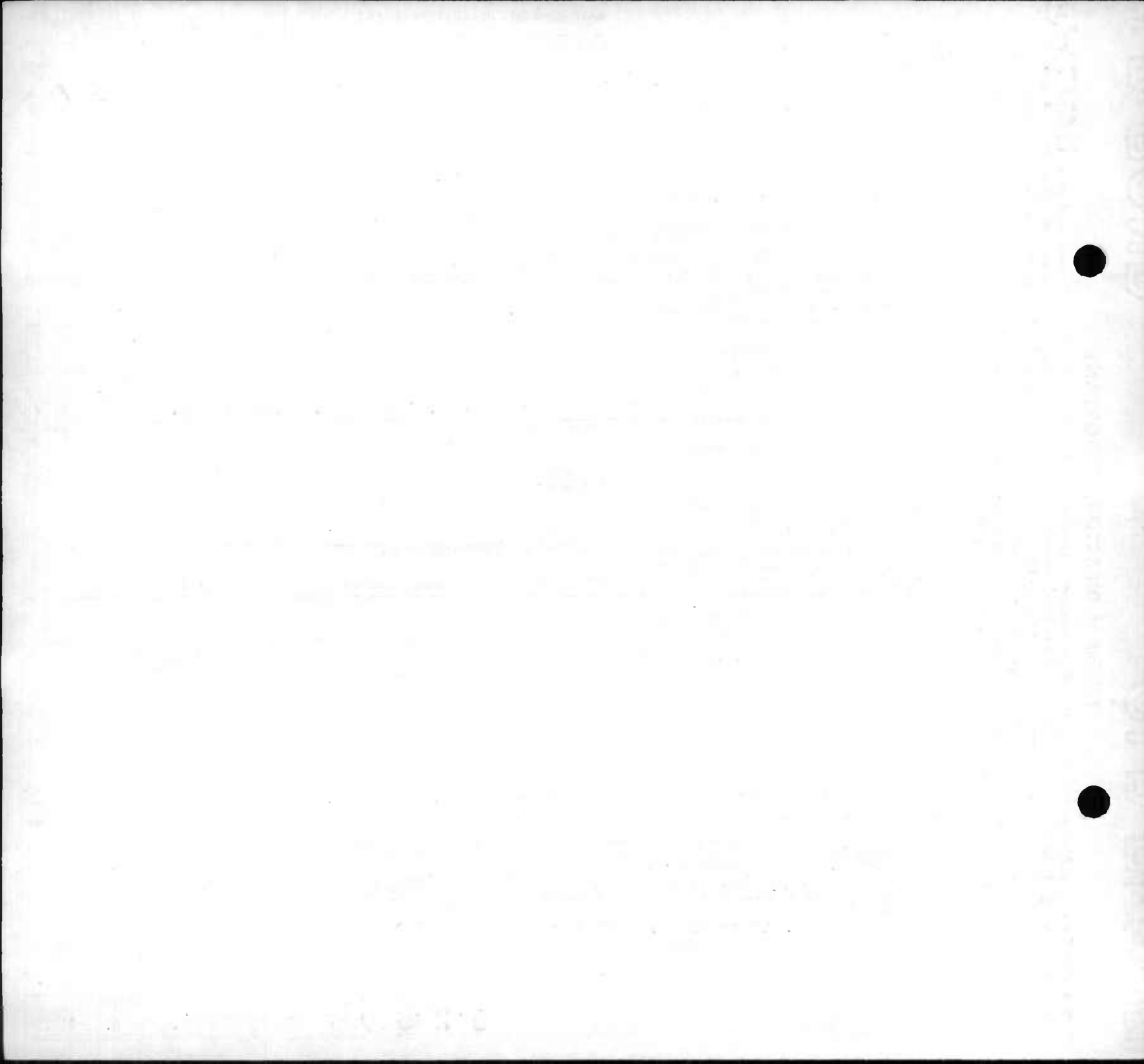
BALTIMORE CITY HEALTH DEPARTMENT				72 00259	
CERTIFICATE OF DEATH				REG. NO. 72 00259	
1. NAME OF DECEASED (Type name in full) <b>John E. Clark</b>			2. DATE AND HOUR OF DEATH <b>1-10-72 10:25 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Mercy Hospital 37</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2748</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5670 ALEMEDA</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-17-98</b>	9. AGE (In years last birthday) <b>73</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor Merchandise Montgomery-</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Ward</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John E. Clark</b>		
14. MOTHER'S MAIDEN NAME <b>Sara Brown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		
16. SOCIAL SECURITY NO. <b>070-01-1946A</b>			17. INFORMANT ADDRESS <b>Mrs. Ernestine R. Clark Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic obstructive lung disease</b> <b>Pneumonia</b> <b>Atherosclerotic heart disease</b> <b>atrial fibrillation</b> <b>Chronic kidney disease</b> <b>Respiratory distress</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21G. WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> 19 <b>71</b> to <b>1/10</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Nicann F. Joaquin</b>				23B. DATE SIGNED <b>Jan 10, 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Nicann F. Joaquin</b>				23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>1-13-72</b>		<b>Moreland Memorial Park</b>	
24D. LOCATION		24E. LOCATION (City, town, or county) (State)			
<b>Balto. Co., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JAN 11 1972</b>		<b>Beck, S. A., Jr.</b>		<b>H. W. Jenkins &amp; Sons Co.</b>	
				ADDRESS <b>2405 York Road Balto., Md. 21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

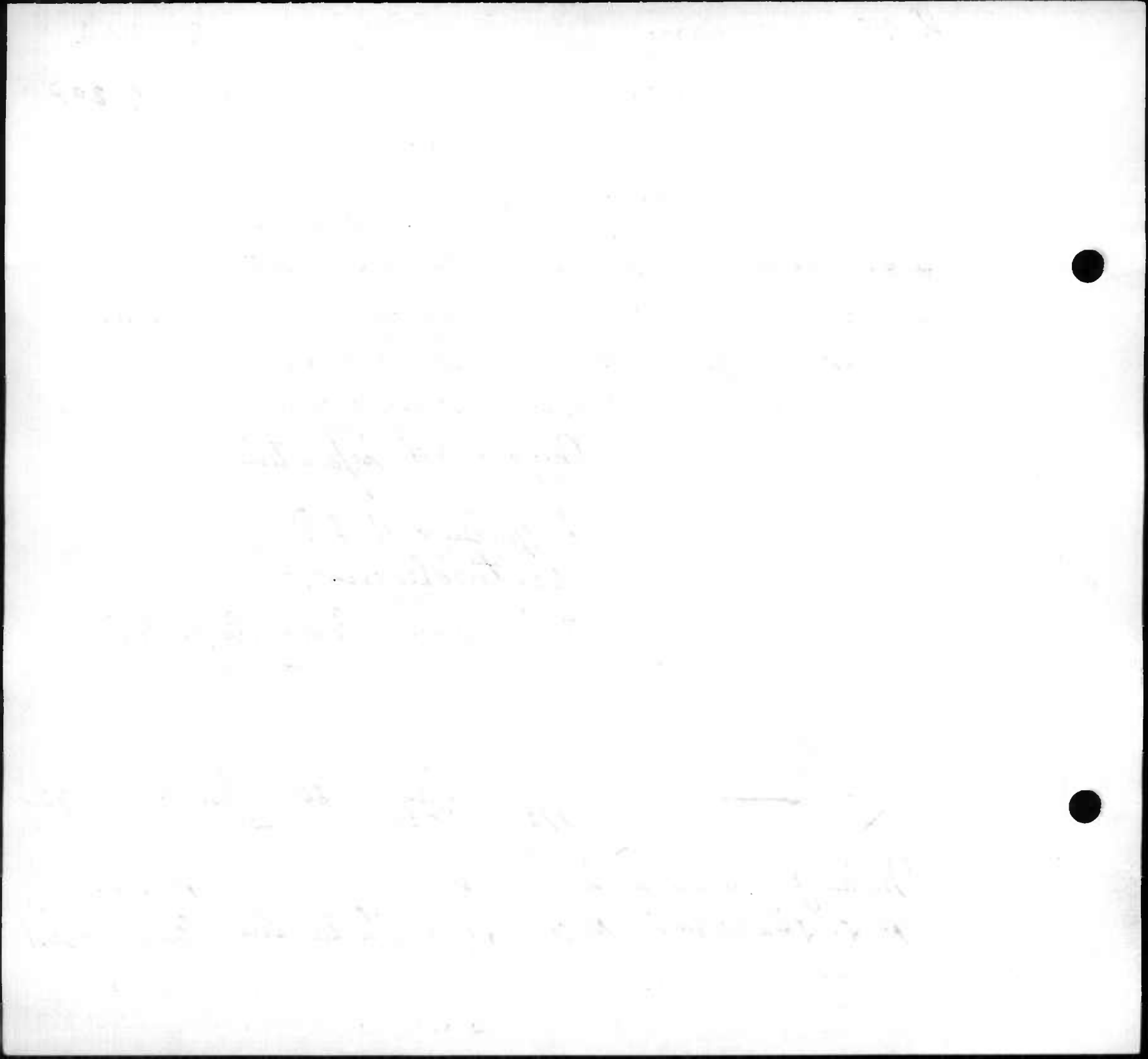
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00250	
B-460 72 00250				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Michael S. Blair		2. DATE AND HOUR OF DEATH Jan. 8, 1972 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 6305 Mayflower Road			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 2768 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6305 Mayflower Road 21212		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1886	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10B. KIND OF BUSINESS OR INDUSTRY Blair & Sons, Inc.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Blair			14. MOTHER'S MAIDEN NAME Ann		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-6778		17. INFORMANT ADDRESS Mr. Elmer J. Blair 31 E. Seminary Ave 21204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  5-93-21 CORONARY OCCLUSION HYPERTENSION ARTEROSCLEROTIC CHANGES RENAL VASCULAR DISEASE  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY OCCLUSION (B) DUE TO, OR AS A CONSEQUENCE OF: ARTEROSCLEROTIC CHANGES (C) RENAL VASCULAR DISEASE  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 10 ± yrs		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 Oct 19 47 to 8 January 19 72 that (I) (we) last saw the deceased alive on 7 January 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles F. O'Donnell				23B. DATE SIGNED 1/11/72	
23C. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		23D. ADDRESS 7501 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-12-72		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial Gardens	
24D. LOCATION (City, town, or county) Timonium, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 11 1972			
25B. NAME OF REGISTRAR Charles F. O'Donnell		25C. FUNERAL DIRECTOR J. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00261</u>	
BIRTH NO. <u>P-125</u>		72 00261			
1. NAME OF DECEASED (Type or Print) <u>John George Pipkin (Pepka)</u>			2. DATE AND HOUR OF DEATH <u>January 9, 1972</u> <u>7:20 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home &amp; Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>105</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>331 S. Chester Street</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1900</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipfitter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Ship Repair</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Pipkin (Pepka)</u>			14. MOTHER'S MAIDEN NAME <u>Frances Biniak</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-3086</u>		17. INFORMANT <u>Mr. Edward Pipkin, 1621 Searles Road</u>	
18. <u>418.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension C.V.D.</u> <u>Arteriosclerosis</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>3 - Pneumonia, Coronary Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>Jan 5</u> 19 <u>72</u> to <u>Jan 9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/5/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael J. Jaworski M.D.</u>			23B. DATE SIGNED <u>1/10/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>M. J. JAWORSKI M.D.</u>			23D. ADDRESS <u>2711 Eastern Ave, Balto 24 Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/13/72</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>OF SADOWSKI &amp; SONS, 1808 EASTERN AVE</u>	

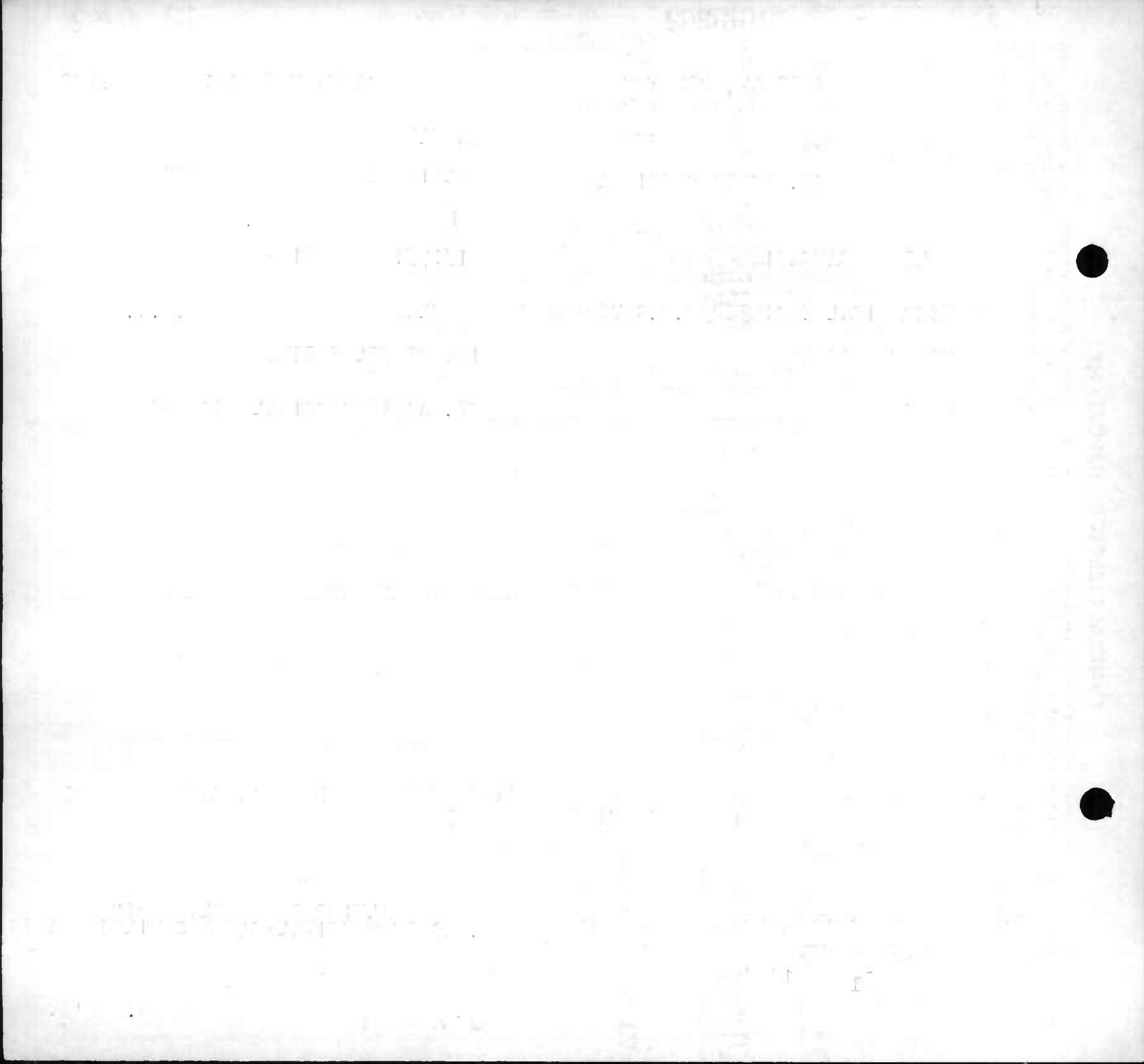




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

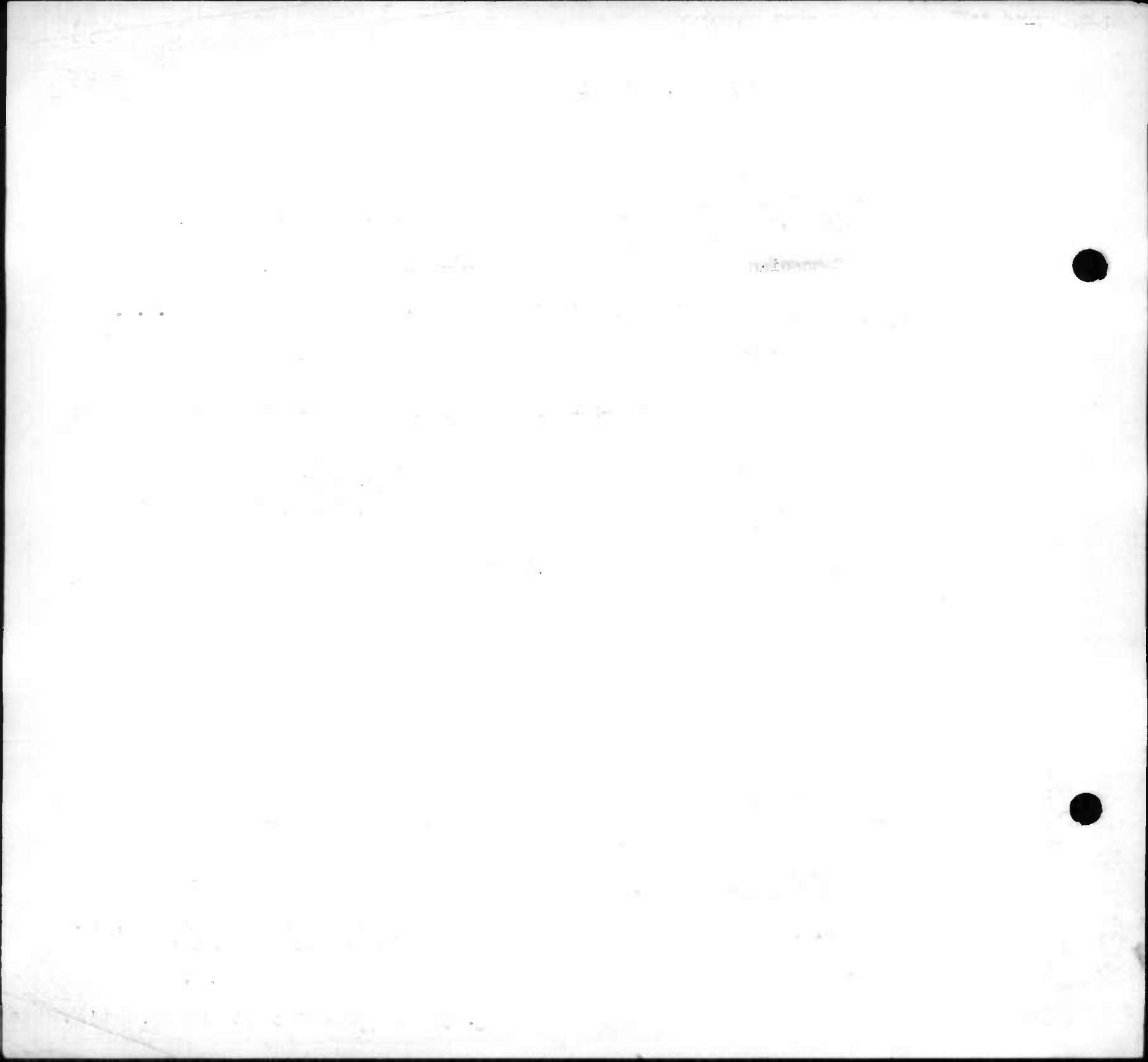
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00262	
7-655 72 00262				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FREEMAN, HENRY H				2. DATE AND HOUR OF DEATH JANUARY 6, 1972 2:15P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2834	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 01/17/10		9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANICAL ENGINEER U.S. GOVERNMENT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME HENRY FREEMAN	
14. MOTHER'S MAIDEN NAME IDA HERPEL FREEMAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO.	
17. INFORMANT ST. AGNES HOSPITAL RECORDS		ADDRESS		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Respir. failure	
ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Co of esophagus 10 mo	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 2/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		Emphysema Aortic	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 6 1972 to JANUARY 6 1972 that (I) (we) last saw the deceased alive on JANUARY 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] OEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JOSE APTER MD				23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/8/1972		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR Schwab 5151 Balto. Nat'l. Pike	
25A. DATE REC'D BY HEALTH DEPT. JAN 11 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-240 72 00263		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00263	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William F. Wissel		1-7-72 5:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland Baltimore 5300	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER					
6031 Burnt Oak Road				21228	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-6-1909	62	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laundry Manager		City Hospital		New Jersey	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Albert		Lillian		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		138-26-4356		Records: BCH-4940 Eastern Avenue 21224	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sudden Death cause probable Acute Myocardial Infarction					
(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD					
(C) Probable Metastatic Cancer					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
10 yrs.					
1 yr					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-3-72 to 1-7-72 that (I) last saw the deceased alive on 1-6-72 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
W.L. Ramseur MD.				1-7-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
W.L. Ramseur				4940 Eastern Avenue, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24C. NAME of CEMETERY or CREMATORY	
Removal				24D. LOCATION (City, town, or county) (State)	
24B. DATE 1/9/1972				Somerville, N.J.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 11 1972		W.L. Ramseur, M.D.		T. J. Schwab 5151 Balto. Nat'l. Pike	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00264</u>
<p>0-241 72 00264</p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>Loretta Mary O'Sullivan</b></p>		<p>2. DATE AND HOUR OF DEATH <b>Jan. 5th, 1972</b></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3507 N. Charles Street 2-9-72</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1202</b></p> <p>C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>3507 N. Charles St.</b></p>		
<p>5. SEX <b>Female</b> 6. RACE <b>White</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>Sept. 15, 1901</b> 9. AGE (In years last birthday) <b>70 69</b></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b></p> <p>11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b></p> <p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>		
<p>13. FATHER'S NAME <b>Thos. J. McGrain</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary Tanyne</b></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no ---</b></p>		<p>16. SOCIAL SECURITY NO. <b>214-38-0216</b></p> <p>17. INFORMANT <b>Mr. D. Chester O'Sullivan (Husband)</b></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arterial Corrosion + thrombosis</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH <b>Arterial Corrosion + thrombosis</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b></p>		
<p>19. DATE OF OPERATION <b>1-10-72</b></p>		<p>20. AUTOPSY? (Yes or No) <b>NO</b></p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		
<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <b>3-79</b> to <b>1-5</b> 19 <b>72</b> that (I) (<del>we</del>) last saw the deceased alive on <b>11-19</b> 19 <b>71</b> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>did</del>) view the body after death.</p>		
<p>23A. SIGNATURE </p>		<p>23B. DATE SIGNED <b>1-6-72</b></p>		
<p>23C. PHYSICIAN'S NAME (Type) <b>M. Friedman M.D.</b></p>		<p>23D. ADDRESS <b>5211 Harford Rd. Balto, MD, 21214</b></p>		
<p>24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>1/8/72</b></p>		
<p>24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b></p>		<p>24D. LOCATION <b>Balto.</b></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Mitchell Wiedefeld</b></p>		
<p>25C. FUNERAL DIRECTOR <b>6500 York Rd.</b></p>		<p>ADDRESS</p>		

2-9-1972 - Correction form from Funeral Director.

HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00265</u>	
C-625 72 00265				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Carrigan, Mrs. Rose E</u>		2. DATE AND HOUR OF DEATH <u>1-5-72</u> <u>12<sup>55</sup></u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2714</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4612 Roland Ave</u>		E. STREET AND NUMBER	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1885</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Adamschoff</u>		14. MOTHER'S MAIDEN NAME <u>Rose Stumph</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-14-7640</u>		17. INFORMANT <u>Keswick Records</u>	
18. <u>437.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Arteriosclerosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardiovascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Osteoarthritis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>6 yrs</u> <u>9 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 4</u> <u>1966</u> to <u>JAN 5</u> <u>1972</u> , that (I) (we) last saw the deceased alive on <u>5 Jan</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Aubrey D. Richardson, M.D.</u>				23B. DATE SIGNED <u>5 Jan 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson, M.D.</u>				23D. ADDRESS <u>700 W. 40th Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Belair Rd. Balto Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Edna E. Bailey</u>	
25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>		ADDRESS <u>6500 York Rd.</u>			

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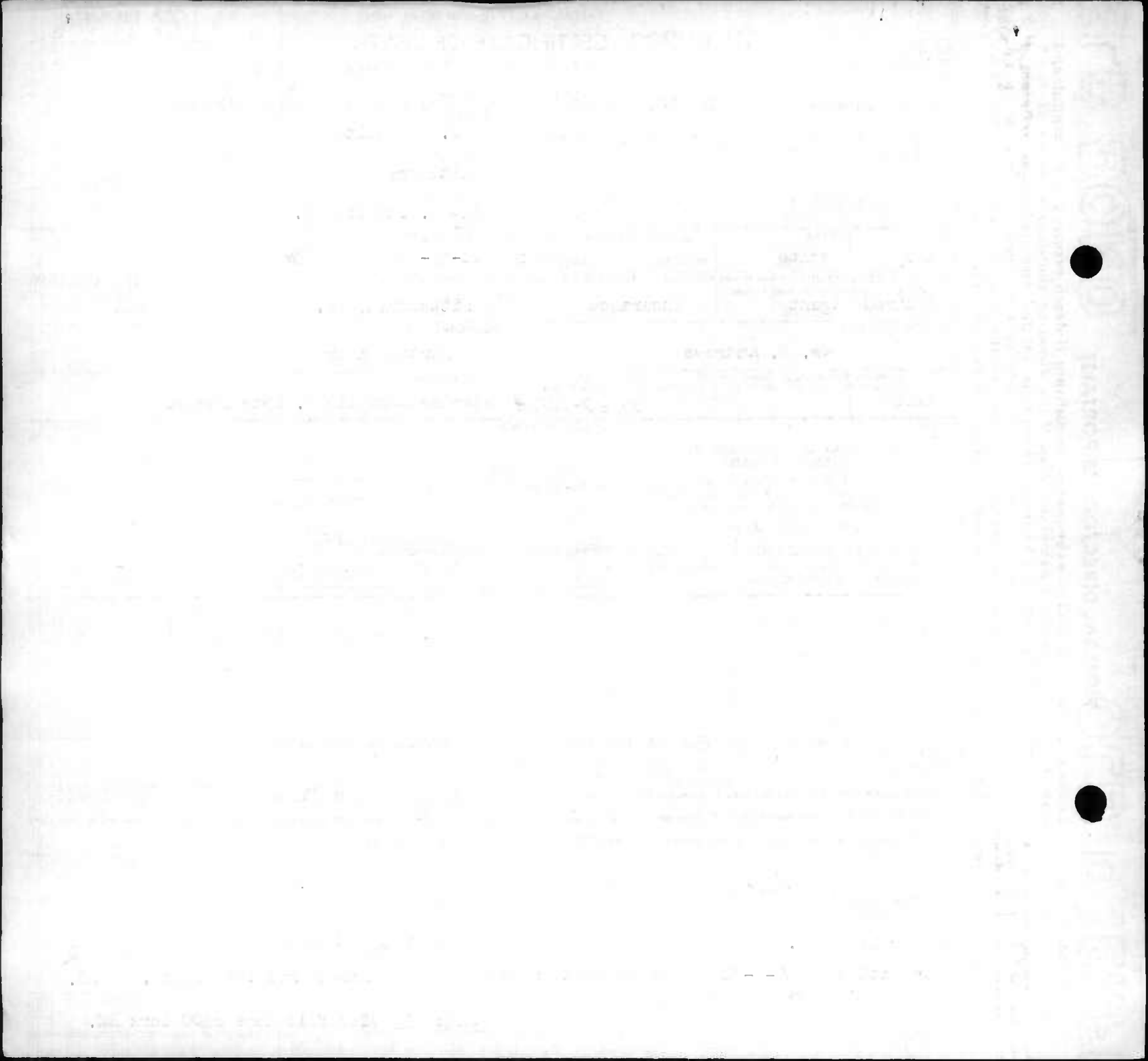
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00266	
A-536 72 00266					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>William L. Andrews</u>			2. DATE AND HOUR OF DEATH <u>1-3-72</u> <u>8:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>524 N. Charles St.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1901</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Agent</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wm. L. Andrews</u>		14. MOTHER'S MAIDEN NAME <u>Martha Piper</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>13-07-2131A</u>		17. INFORMANT <u>Charles Cobb 116 E. 25th Street</u>	
18. <u>486X I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>Cardiac Failure</u> <u>4 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>Renal Failure</u> <u>1 day</u>	
		(C) DUE TO, OR AS A CONSEQUENCE OF:		<u>Massive pneumonia</u> <u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>ASCVD, chronic ETOHism</u>		<u>years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> 19 <u>72</u> to <u>1-3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-3</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael V. Edelstein</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Michael V. Edelstein</u>				23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Greenmount Ave Balto. Md.</u>	
25A. DATE OF DEATH <u>JAN 11 1972</u>		25C. NAME OF REGISTRAR <u>Mitchell Wiedefeld</u>		25D. FUNERAL DIRECTOR ADDRESS <u>Home 6500 York RD.</u>	



FUNERAL DIRECTOR: IMPORTANT

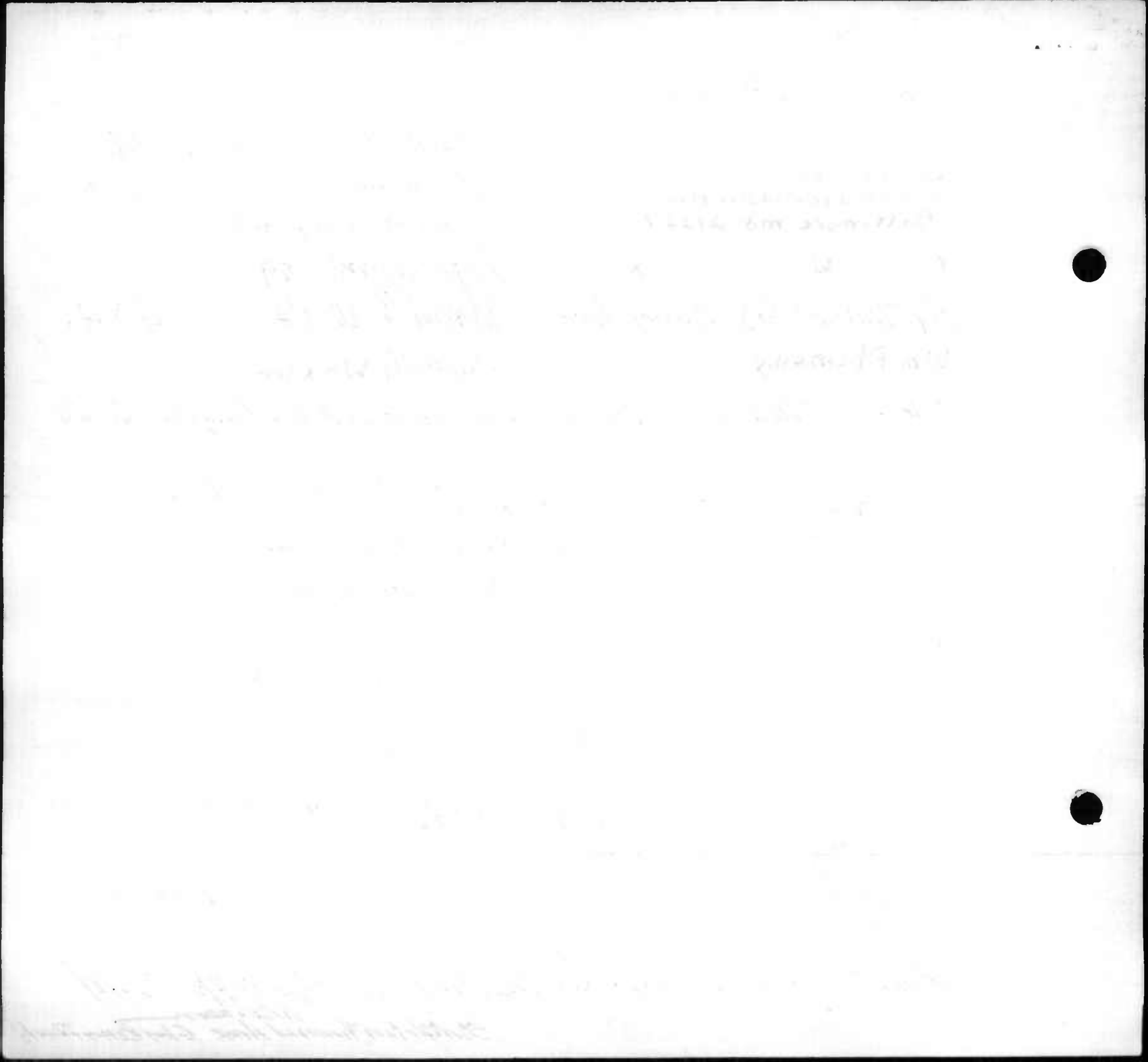
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-655 72 00267

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00267

BIRTH NO. 0-655 72 00267		1. NAME OF DECEASED (Type or Print) <b>Mrs. Bessie S. Orman</b>		2. DATE AND HOUR OF DEATH <b>1-10-72 9:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Hood Convalescent Home 5313 Edmondson Ave Baltimore Md. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> C. CITY OR TOWN <b>Birthicum</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>528 Shipley Rd.</b>	
5. SEX <b>F.</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1882</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Nurse (Ret)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Nursing Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mineral Co. W. VA.</b>	
13. FATHER'S NAME <b>Wm. Abernathy</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Waxler</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-24968</b>		17. INFORMANT <b>Mrs. Christina E. Rice (daughter)</b>	
18. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>1</b> This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause 1A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <b>ACUTE PULMONARY EDEMA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ANTENATAL SCLEROTIC CHANG</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>UNCULNA INJURY</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-9-72</b> to <b>1-10-72</b> that (I) (we) last saw the deceased alive on <b>1-9-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>1-10-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				23D. ADDRESS <b>[Address]</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/11/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Brooklyn Park</b>	
24D. LOCATION (City, town or county) (State) <b>Brooklyn Park Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>	
25C. FUNERAL DIRECTOR <b>[Signature]</b>		25D. ADDRESS <b>[Address]</b>			



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS DUVALL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 8, 1972</b>		Hour <b>11:10 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 8, 1972</b>		Hour <b>11:10 P.M.</b>
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>April 21, 1904</b>		10. AGE (In years last birthday) <b>67</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SAMUEL O. DUVALL</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC (ret.)</b>
15. MOTHER'S MAIDEN NAME <b>VIRGINIA WADE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>217 01 1063</b>
18. INFORMANT <b>MRS. ELSIE LANHAM (daughter)</b>		ADDRESS <b>Maryland Crownsville,</b>		
19. CAUSE OF DEATH <b>E870X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Gambrille, Maryland</b>
22D. TIME OF INJURY (APPROX.) <b>1-8-72 8:30 P.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Found in burning house</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 9, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN. 12/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>FORT LINCOLN, CEMETERY</b>
24D. LOCATION (City, town, or county) (State) <b>BLADENSBURG, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>SINGLETON FUNERAL HOME</b>		
25D. ADDRESS <b>GLEN BURNIE, MARYLAND</b>				

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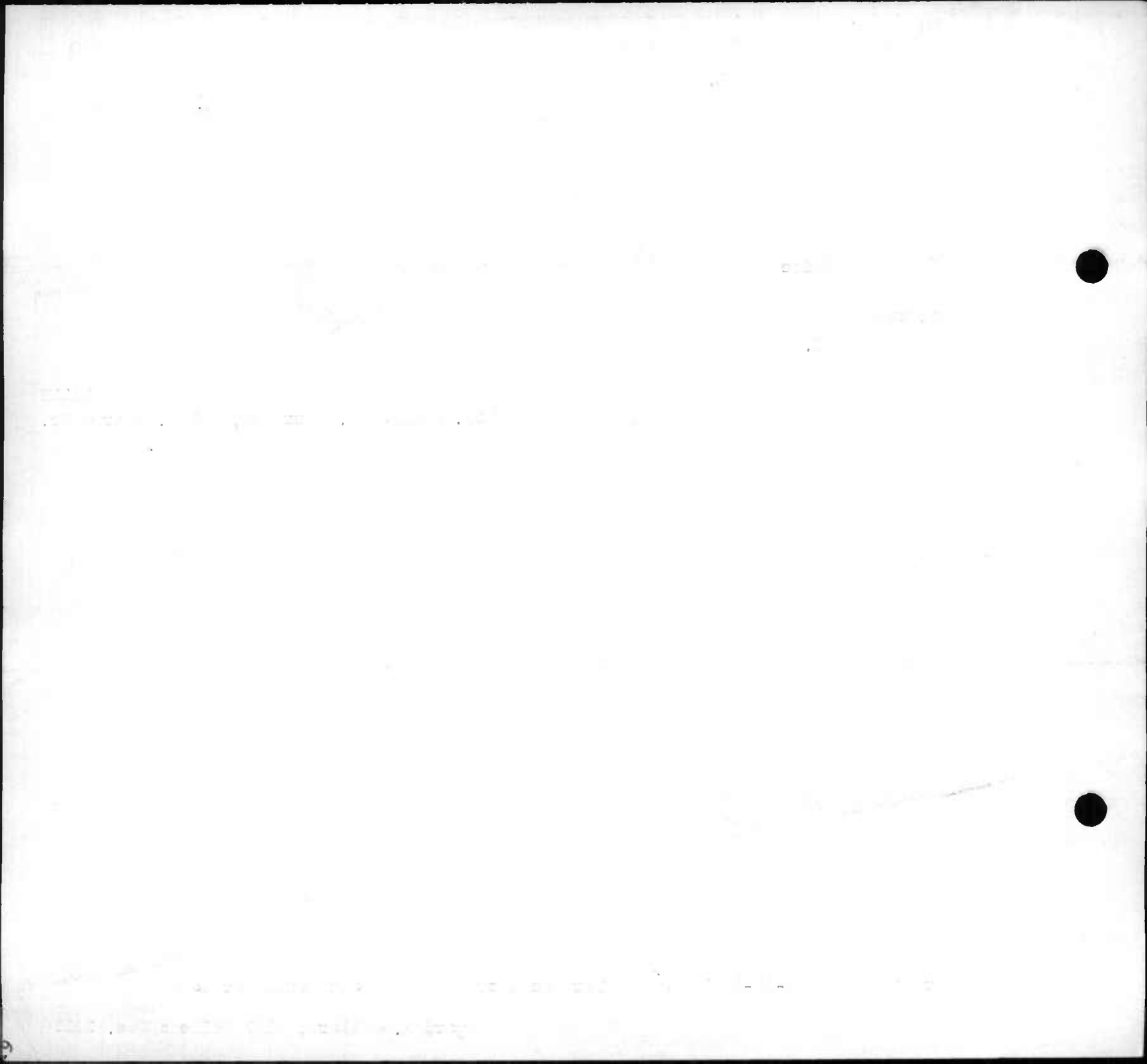
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

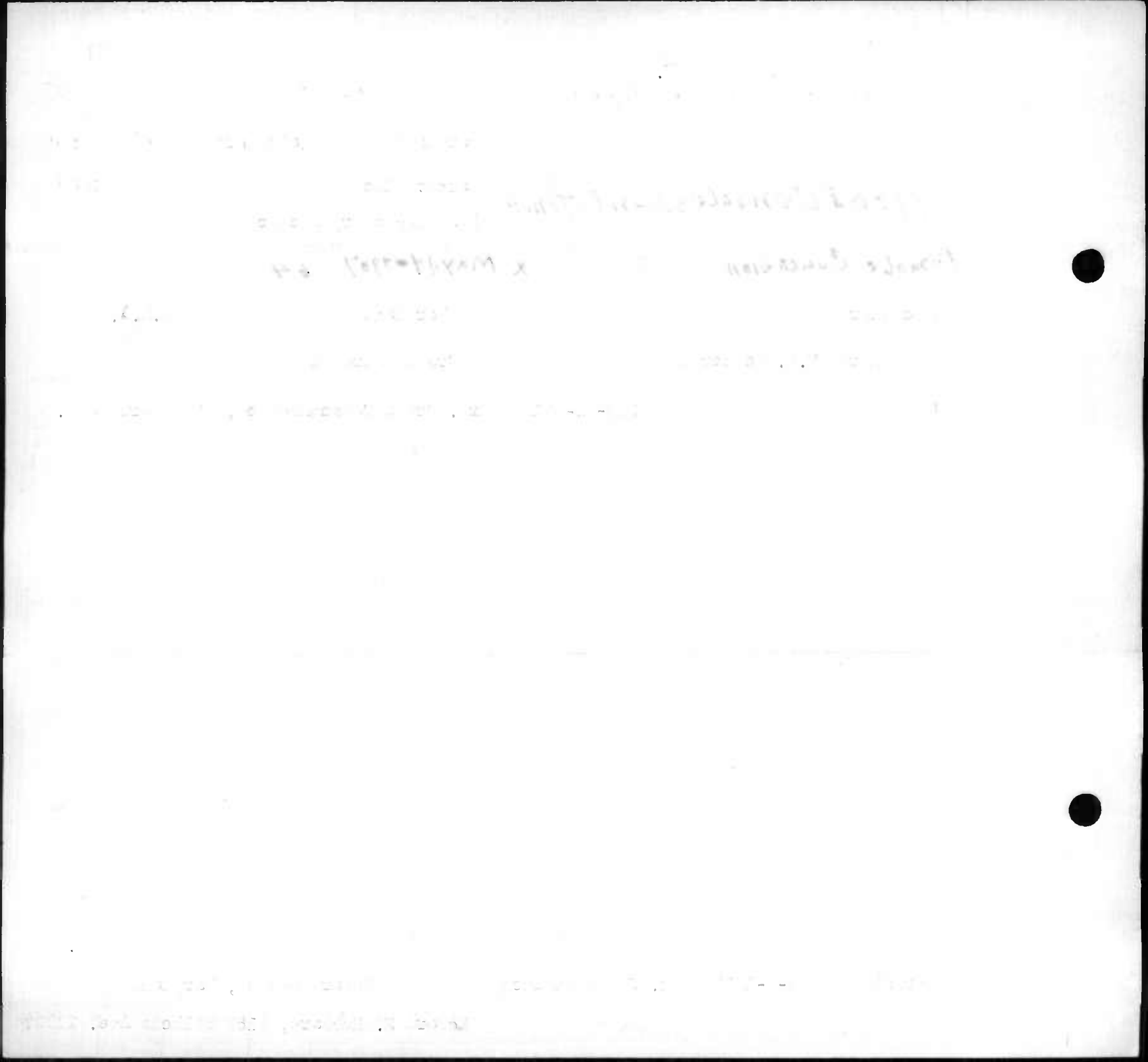
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00269	
M-625 72 00269		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>L. Richard Morrison</i>		2. DATE AND HOUR OF DEATH <i>January 5, 1972 8:50 p.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>34 Bon Secours Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2005</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>412 Furrow St.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/03/02</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Gas &amp; Electric Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>L. Richard Morrison</i>		14. MOTHER'S MAIDEN NAME <i>Agusta Liechtenburg</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-05-4439</i>		17. INFORMANT <i>Mrs. Lillian V. Morrison, 412 S. Furrow St.</i>	
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Carcinoma both legs (hemogeneous ca.)</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>11-30-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>st. cervical node biopsy</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-24</i> 19 <i>71</i> to <i>1-5</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1-5</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Malinee Yunyongying</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>MALINEE YUNYONGYING</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-10-1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. ADDRESS <i>BON SECOURS HOSPITAL, BALTIMORE, MD 21223</i>		24F. DATE REC'D BY HEALTH DEPT. <i>JAN 11 1972</i>	
25A. NAME OF REGISTRAR <i>Robert E. ...</i>		25B. NAME OF REGISTRAR <i>7 2 0 0</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21227</i>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00270	
<div style="display: flex; justify-content: space-between;"> <span>M-620</span> <span>72 00270</span> </div>							
1. NAME OF DECEASED (Type or Print) <i>Anna Caroline Myers</i>				2. DATE AND HOUR OF DEATH <i>1-5-72 4:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Hood Convalescent Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
				C. CITY OR TOWN <i>Catonsville</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>305 Bloomsbury Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>May 14-1907</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Andrew V.D. Westervelt</i>				14. MOTHER'S MAIDEN NAME <i>Grace Strange</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>213-03-3715</i>		17. INFORMANT ADDRESS <i>Mrs. Grace Tausendschoen, 1240 Birch Ave. 21227</i>	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Acidosis - Dehydration</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <i>Undetermined fever</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <i>Severe crippled rheumatoid arthritis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 5 1972</i> to <i>Jan 5 1972</i> that (I) (we) last saw the deceased alive on <i>Jan 5 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stanley B. Nichols</i>				23B. DATE SIGNED <i>1-5-72</i>			
23C. PHYSICIAN'S NAME (Type) <i>STANLEY B. NICHOLS</i>				23D. ADDRESS <i>1101 Maiden Choice La Post</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-8-1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Johns Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Howard County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 11 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Baker</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		ADDRESS <i>4107 Wilkens Ave. 21227</i>	



# FUNERAL DIRECTOR: IMPORTANT

49-06-45 1csk

H-630

72 00271

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 00271

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Ida Mae Hart*

2. DATE AND HOUR OF DEATH

*Jan. 7, 1972 3<sup>50</sup> P.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*31* Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland *2611*

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

940 S. Bouldin St. Baltimore, Md 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-6-81

9. AGE (in years last birthday)

90

11. Under 1 Yr. Months: Days: Hours: Min.

12. Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Gibbons

14. MOTHER'S MAIDEN NAME

Clara

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT 4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Md. 21224

18. *417.0 I*

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*Respiratory Arrest*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF

*Congestive Heart Failure 6 months*

(C) *x x x x x x x x x x*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

*Restrictive*

*Chronic Obstructive Pul. Disease*

*20 years*

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

*NO*

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from *Dec. 27 1971* to *Jan. 7 1972* that (I) (~~was~~) last saw the deceased alive on *Jan. 7 1972* and that (in my) (~~own~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was~~) (~~did not~~) view the body after death.

23A. SIGNATURE

*J. E. Menitove, MD*

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

*1/7/72*

23C. PHYSICIAN'S NAME (Type)

*JAY E. MENITOVE MD*

23D. ADDRESS

*Balt. City Hosps  
Balt. Md 21224*

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-9-1972

24C. NAME of CEMETERY or CREMATORY

Oak Hall Cemetery

24D. LOCATION

Oak Hall, Cemetery

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

*JAN 11 1972*

*Howard H. Hubbard, 4107 Wilkens Ave. 21229*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

175-183

ATC - TRANSPORTATION

COMMUNICATIONS

175-183



175-183

ATC - TRANSPORTATION

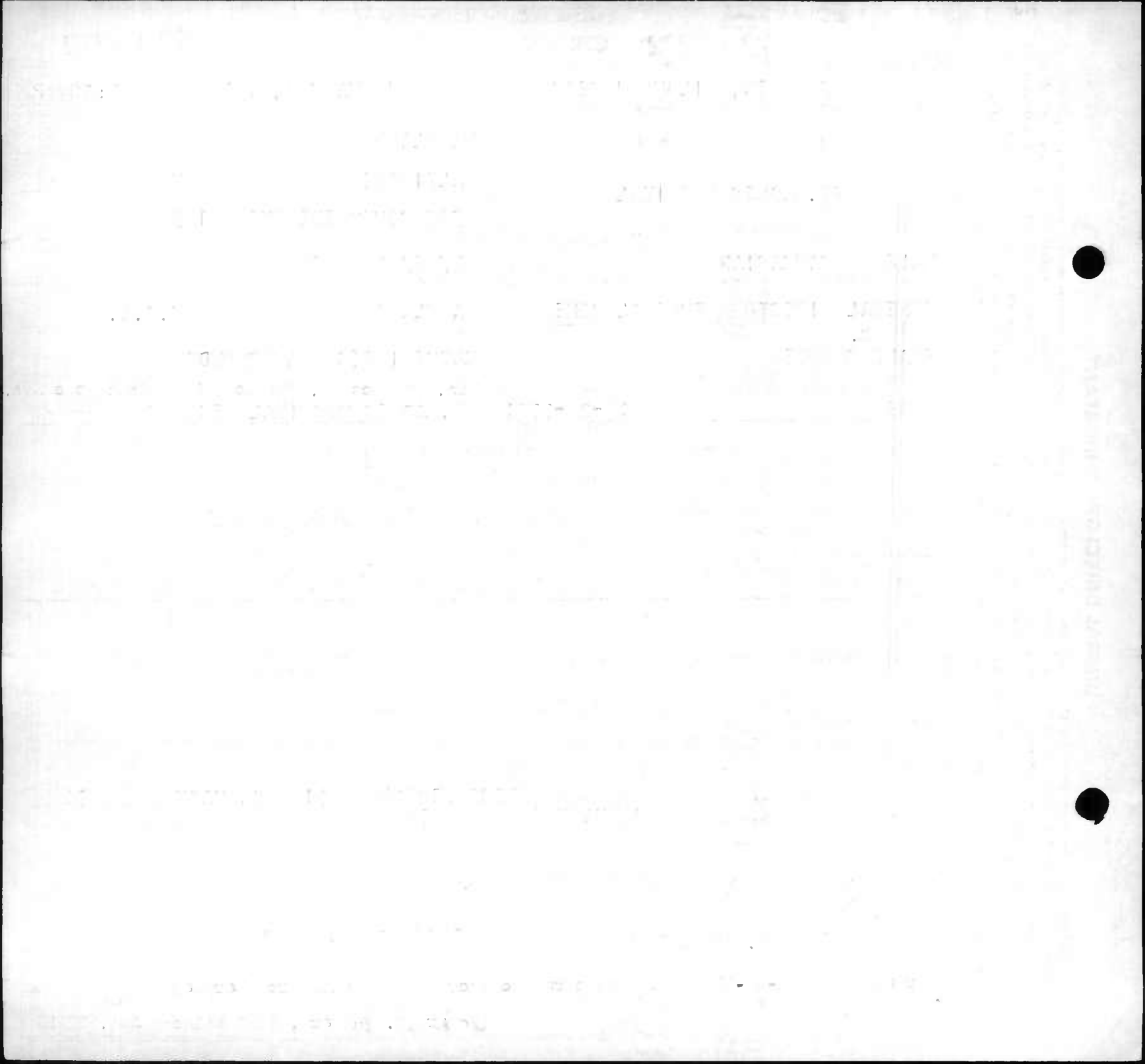
175-183

175-183

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

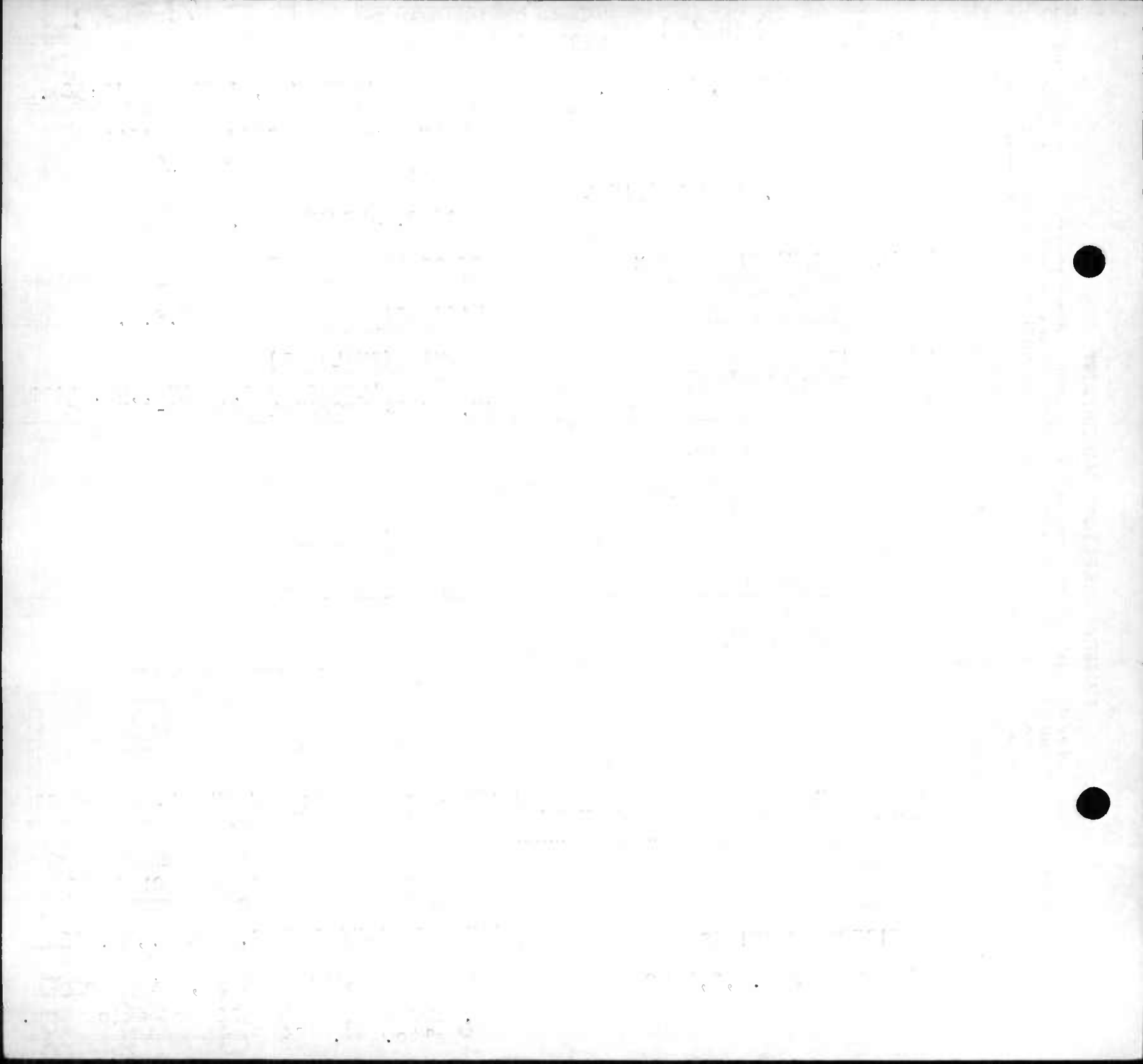
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00272	
S-535 72 00272				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SNOWDEN, WILBUR JOSEPH		JANUARY 6, 1972		3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL		MARYLAND		2572	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2565 SOUTHdene AVE 21230			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	04/06/02	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
FUNERAL DIRECTOR		FUNERAL HOME		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
FRANK SNOWDEN		CATHERINE (CONWAY) SNOWDEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NONE		219-20-7721		Mrs. Kathleen R. Snowden, 2565 Southdene Ave. ST. AGNES HOSPITAL RECORDS 21230	
18. 519.3 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Respiratory Failure			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE			
DUE TO, OR AS A CONSEQUENCE OF:		Pneumonitis RLL, LLL			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Chronic Obstructive Pulmonary Disease			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 24 1971 to JANUARY 6 1972					
that (I) (we) last saw the deceased alive on JANUARY 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Joseph H. Miller MD		January 7, 1972			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOSEPH H. MILLER MD		CATON & WILKENS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-10-72		New Cathedral Cemetery	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore, Maryland		Howard H. Hubbard, 4107 Wilkens Ave. 21229			
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 11 1972		Robert E. Taylor, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">72 00273</span>	
<b>BIRTH NO.</b> <div style="font-size: 2em; margin-left: 10px;">M-220</div>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">MACZIS, LEONA O.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span>  <div style="font-size: 2em; margin-left: 10px;">40</div> <span style="float: right;">ST. AGNES HOSPITAL</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="float: right;">JANUARY 6, 1972   12:30A.M.</span>			
<b>5. SEX</b> FEMALE		<b>6. RACE</b> CAUCASIAN		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) House Wife		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">CITY</span> <span style="float: right;">21229</span>	
<b>13. FATHER'S NAME</b> JOHN WEIS		<b>14. MOTHER'S MAIDEN NAME</b> SOPHIA (THALDORF)		<b>8. DATE OF BIRTH</b> 05 20 92	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b>		<b>9. AGE</b> (In years last birthday) <span style="float: right;">79</span> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
<b>11. BIRTHPLACE</b> (State or foreign country) WISCONSIN		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.			
<b>17. INFORMANT</b> WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &		<b>ADDRESS</b>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> ASCVD (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
II					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (X) (this hospital) attended the deceased from DECEMBER 26 19 71 to JANUARY 6 19 72 that (X) (we) last saw the deceased alive on JANUARY 6 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <div style="font-size: 1.5em; margin-left: 10px;">Benauides</div>				<b>23B. DATE SIGNED</b> 01 06 72	
<b>23C. PHYSICIAN'S NAME</b> (Type) VICTOR BENAVIDES				<b>23D. ADDRESS</b> CATON & WILKENS AVES. BALTO. MD. 21229	
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) Removal		<b>24B. DATE</b> Jan. 7, 1972		<b>24C. NAME OF CEMETERY or CREMATORY</b> ? Rolling Stone, Minnesota	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 11 1972		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b> Truman Schwab 3512 Frederick Ave. Balto. Md. 21229	

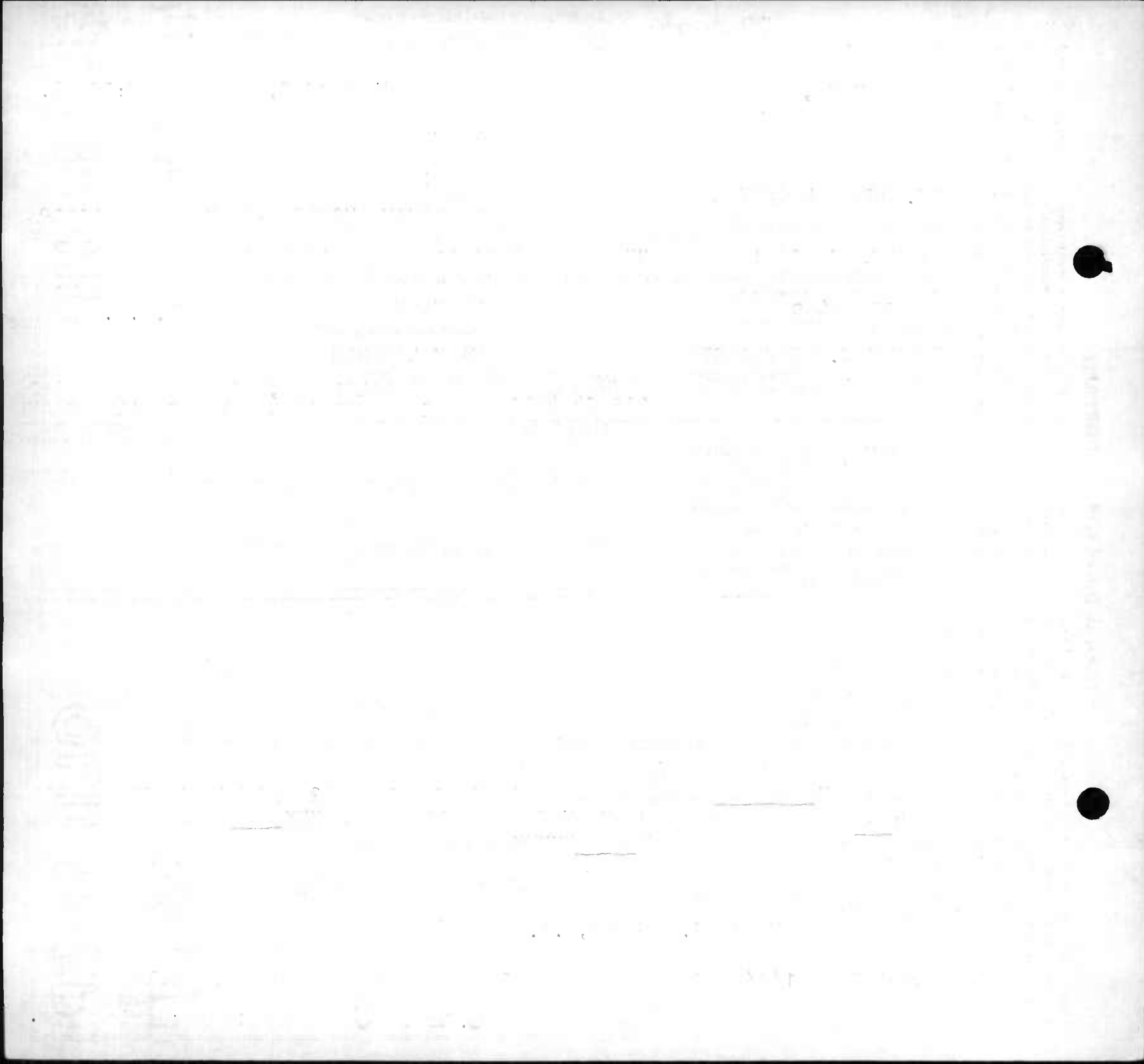




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00274</u>	
B-620 72 00274 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>BURKE, ROSE EILEEN</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 5, 1972</u>   <u>5:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST. AGNES HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2008</u>		
5. SEX <u>FEMALE</u> 6. RACE <u>CAUCASIAN</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11 13 88</u> 9. AGE (In years last birthday) <u>83</u> 10. Under 1 Yr. Months; Days 11. Under 24 Hrs. Hours; Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>THOMAS J. WORTHINGTON</u>			14. MOTHER'S MAIDEN NAME <u>MARY LANAHAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213 54 4913</u>		
17. INFORMANT <u>BALTIMORE, MARYLAND</u> ADDRESS <u>21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVE</u>			18. CAUSE OF DEATH		
16. <u>4-36-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF: <u>and Peripheral Vascular Insufficiency</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CY</u> (C) _____		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X (1)</u> (this hospital) attended the deceased from <u>JANUARY 2</u> 19 <u>72</u> to <u>JANUARY 5</u> 19 <u>72</u> that <u>X (1)</u> (we) last saw the deceased alive on <u>JANUARY 5</u> 19 <u>72</u> and that <u>XXX (our)</u> opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) <u>XXXXX</u> view the body after death.					
23A. SIGNATURE <u>Eduardo G. Romero, M.D.</u>				23B. DATE SIGNED <u>1/5/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDUARDO G. ROMERO, M.D.</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/8/1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>Charles E. ...</u>		25C. FUNERAL DIRECTOR <u>O. Truman Schwab</u> ADDRESS <u>3512 Frederick Ave.</u>	



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH EDWARD JAMES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 8, 1972</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 8, 1972</b>		Hour <b>2:20 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>2/26/36</b>		10. AGE (In years last birthday) <b>35</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>WILLIAM JAMES</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>ELIZABETH JONES</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>ELIZABETH JAMES</b>		ADDRESS <b>284 HERRING CT</b>		19. CAUSE OF DEATH <b>E 970X1</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Gunshot wound of chest</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>284 Herring Court</b>	
22D. TIME OF INJURY (APPROX.) <b>1-8-72 2:00 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by police officer</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type)		M.D. <b>Charles S. Springate, M.D.</b>		DATE SIGNED <b>January 9, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/13/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>Robert F. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph L. Locke</b>		ADDRESS <b>1304 N. Central Ave</b>			

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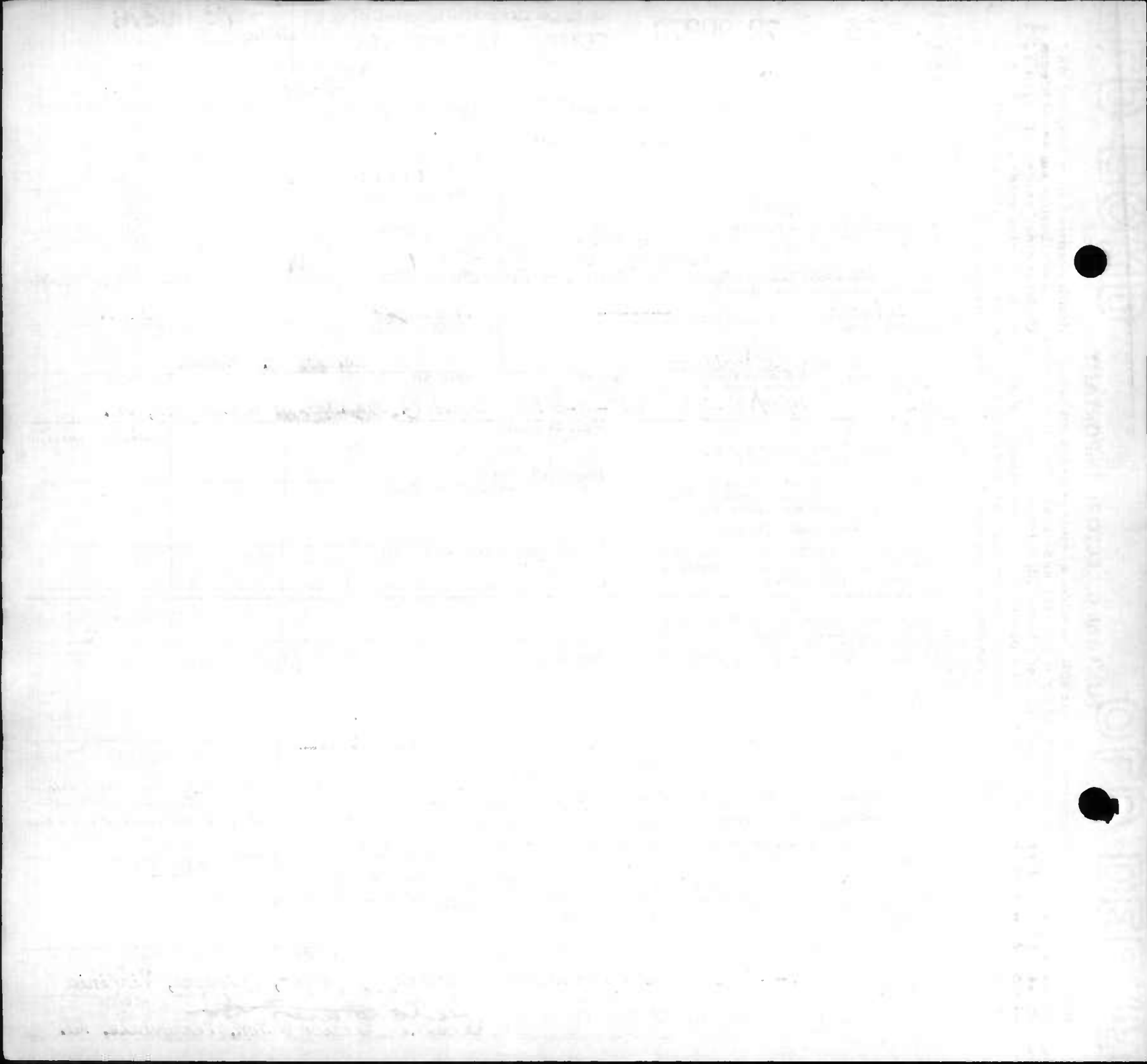
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

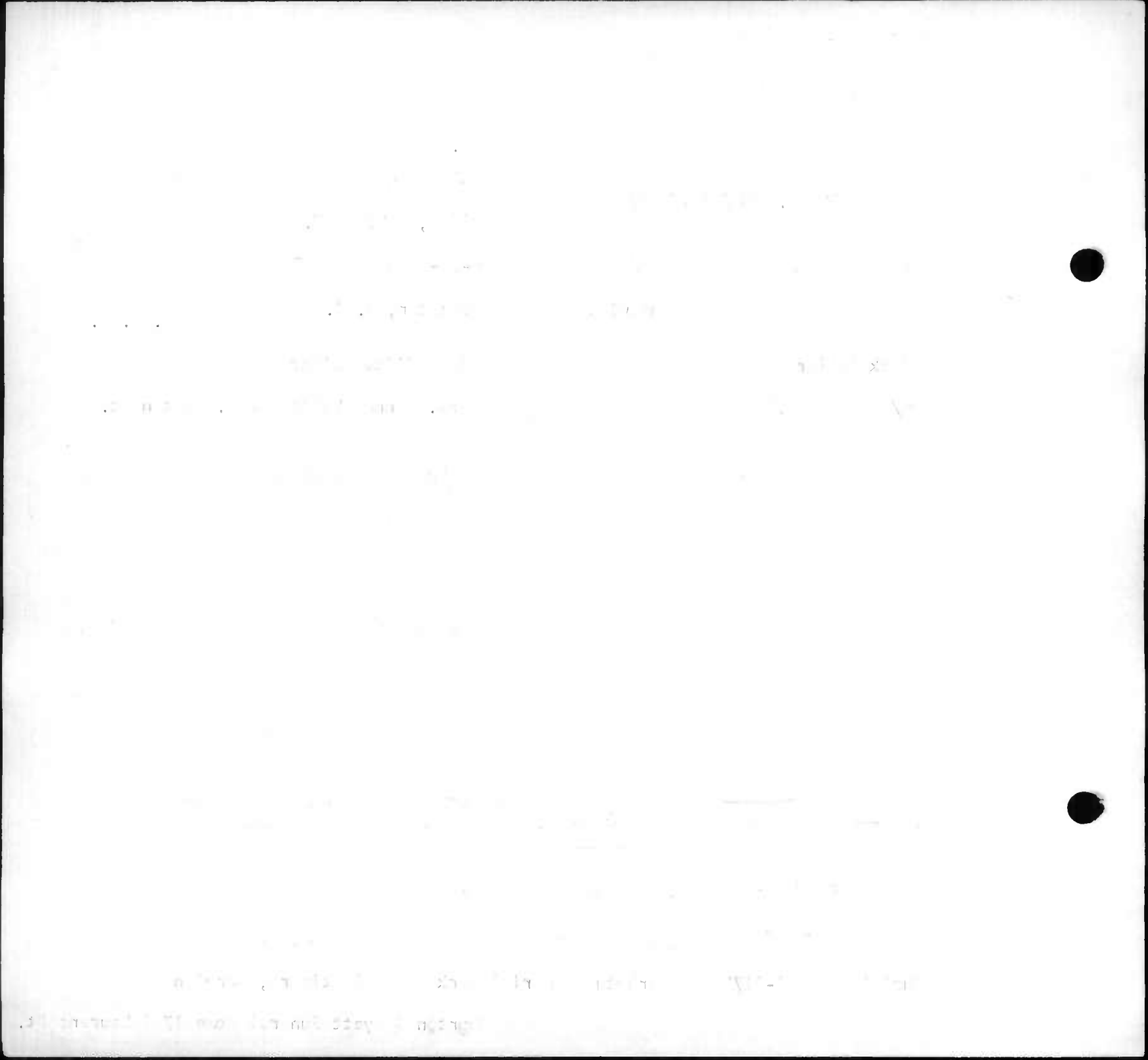
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>G-235</b>		72 00277		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 00277</b>	
1. NAME OF DECEASED (Type or Print) <b>MARY GASTON</b>				2. DATE AND HOUR OF DEATH <b>7 Jan 72</b> <b>5:30 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>416 N. HILTON STREET</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2037</b>					
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>416 N. HILTON ST.</b>					
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-1904</b>		9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Chester, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jack Baller</b>				14. MOTHER'S MAIDEN NAME <b>Emma Eliza Baller</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/a</b>				16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Mrs. Hannah Wells</b> ADDRESS <b>416 N. Hilton St.</b>			
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>151.7</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Gastric Carcinoma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>H. A. C. V. D.</b>				<b>Syns</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov 1968</b> to <b>Nov 1971</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>6 Nov 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.									
23A. SIGNATURE <b>H. H. Baylus MD</b>				23B. DATE SIGNED <b>11 Jan 72</b>				23C. PHYSICIAN'S NAME (Type) <b>H. H. BAYLUS MD</b>	
23D. ADDRESS <b>1600 WILKENS AVE BALTO, MD.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-11-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>REG. 307.23</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett</b> ADDRESS <b>1701 Laurens St.</b>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00278</u>	
BIRTH NO. <u>B-650</u>		72 00278			
1. NAME OF DECEASED (Type or Print) <u>BROWN EULA J.</u>			2. DATE AND HOUR OF DEATH <u>1-6-72 8:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>476</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1506</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2853 W. North Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1902</u>	9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Anderson, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas, Thom</u>			14. MOTHER'S MAIDEN NAME <u>Rosa Thomas</u>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Ellen McMillian</u>		
			ADDRESS <u>2853 W. North Ave.</u>		
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>ASPIRATION</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>C.V.A.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-2-1972</u> to <u>1-6-1972</u> that (I) (we) last saw the deceased alive on <u>1-6-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abbas Arain M.D.</u>			23B. DATE SIGNED <u>1-6-72</u>		
23C. PHYSICIAN'S NAME (Type) <u>ABAS ARAIN M.D.</u>			23D. ADDRESS <u>LUTHERAN HOSP OF MD 730 ARBUTHNOT ST. MD 21216.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memory</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>John E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Morton H. Dyett F.H.</u>	
				ADDRESS <u>1701 Laurens St</u>	

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BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM B. CLAIBORNE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 9, 1972</b>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Siani Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 9, 1972</b>		Hour <b>1:53 A.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>1512</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH <b>12-2-1929</b>		10. AGE (In years last birthday) <b>42</b>		11. BIRTHPLACE (State or foreign country) <b>Prince George Co, Va.</b>	
12. CITIZEN OF <b>U. S. A.</b>		13. FATHER'S NAME <b>John H. Claiborne</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rosewood State Hosp.</b>	
15. MOTHER'S MAIDEN NAME <b>Sallie Winfield</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-55 - 11-26-57</b>			
17. SOCIAL SECURITY NO. <b>216-24-4273</b>		18. INFORMANT ADDRESS <b>Sallie Thomas 2809 Quantico Avenue</b>			
19. <b>E 965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Gunshot wounds of back</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2706 Oswego Street 1513</b>	
22D. TIME OF INJURY (APPROX.) <b>1-9-72 1:05 A.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant at a party</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 9, 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>		25B. NAME OF REGISTRAR <b>Robert S. Jones, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>	

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BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>DONALD LEE</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>January</b> Day <b>9</b> Year <b>1972</b> Hour <b>5:00</b> A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>				3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>9</b> Year <b>1972</b> Hour <b>5:00</b> A. M.	
6. SEX <b>Male</b>				7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1513</b>	
9. DATE OF BIRTH <b>3-15-52</b>				10. AGE (In years last birthday) <b>19</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>				13. FATHER'S NAME <b>Lemuel Lee</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>n/a</b>				15. MOTHER'S MAIDEN NAME <b>Dorothy Lee</b>	
16. SOCIAL SECURITY NO. <b>212-58-4187</b>				17. INFORMANT <b>Mrs. Dorothy Lee</b>	
18. ADDRESS <b>2608 Rosewood Avenue</b>				19. CAUSE OF DEATH <b>E965X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wounds of abdomen and right hip</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>hip</b> <b>(B)</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>	
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2706 Oswego Street</b>	
22D. TIME OF INJURY (APPROX.) <b>1-9-72 1:05 A. m.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant at a party</b>				23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>January 9, 1972</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>1-13-72</b>				24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 11 1972</b>	
25B. NAME OF REGISTRAR <b>John E. [unclear]</b>				25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>	
ADDRESS <b>1701 Laurens St.</b>					

100

100

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00281</u>	
A-400 72 00281 CERTIFICATE OF DEATH					
BIRTH NO. <u>                    </u>					
1. NAME OF DECEASED (Type or Print) <u>John Edward ALLEY</u>			2. DATE AND HOUR OF DEATH <u>6 January 5, 1972</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>                    </u> B. COUNTY <u>                    </u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>6000 Bellona Avenue</u> <u>Edgewood Nursing Home Balto. Md.</u>			Unknown <u>2712</u>		
5. SEX <u>Male</u>		6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1897</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Groom</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Racetrack</u>		9. AGE (In years lost birthday) <u>74</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
13. FATHER'S NAME <u>Unknown</u>			12. CITIZEN OF WHAT COUNTRY? <u>                    </u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213 01 2635</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>
17. INFORMANT <u>Mr. John Boniface</u>			ADDRESS <u>21207 6314 Windsor Mill Rd.</u>		
18. <u>437.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral vascular accident</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>old + new.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized severe cerebral arteriosclerosis</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>                    </u>		
			(C) <u>                    </u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Seizure disorder</u>			<u>few mos.</u>		
19A. DATE OF OPERATION <u>                    </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>                    </u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>                    </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>                    </u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>                    </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>                    </u>	
22. I certify that (I) (this hospital) attended the deceased from <u>February 1968</u> to <u>1/6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen Margolis</u>			23B. DATE SIGNED <u>Jan. 6, 1972</u>		
23C. PHYSICIAN'S NAME (Type) <u>Stephen Margolis, M. D.</u>			23D. ADDRESS <u>9115 Reisterstown Road</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8 JAN 72</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1972</u>		25B. NAME OF REGISTRAR <u>                    </u>		25C. FUNERAL DIRECTOR <u>O. E. Lowell</u>	
				ADDRESS <u>6500 York Road</u>	

6000 BELLOVA AVE



72 00282 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.


1. NAME OF DECEASED (Type or Print) <b>Joseph Chapman</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 11 72 3:40 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2114 Callow Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 11 72 3:40 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1302</b>	
9. DATE OF BIRTH <b>12/11/1900</b>		10. AGE (In years last birthday) <b>71</b>	
11. BIRTHPLACE (State or foreign country) <b>Camaleto Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
13. FATHER'S NAME <b>unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>	
15. MOTHER'S MAIDEN NAME <b>unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>213-07465</b>		18. INFORMANT <b>Joseph Chapman</b>	
19. <b>412.4</b> CAUSE OF DEATH		ADDRESS <b>Beet 30</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner H. Spitz, M.D.</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner H. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-11-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11 13 72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>	
25C. FUNERAL DIRECTOR <b>Albert [unclear]</b>		ADDRESS <b>2302 W. North Ave. Balt 1674</b>	

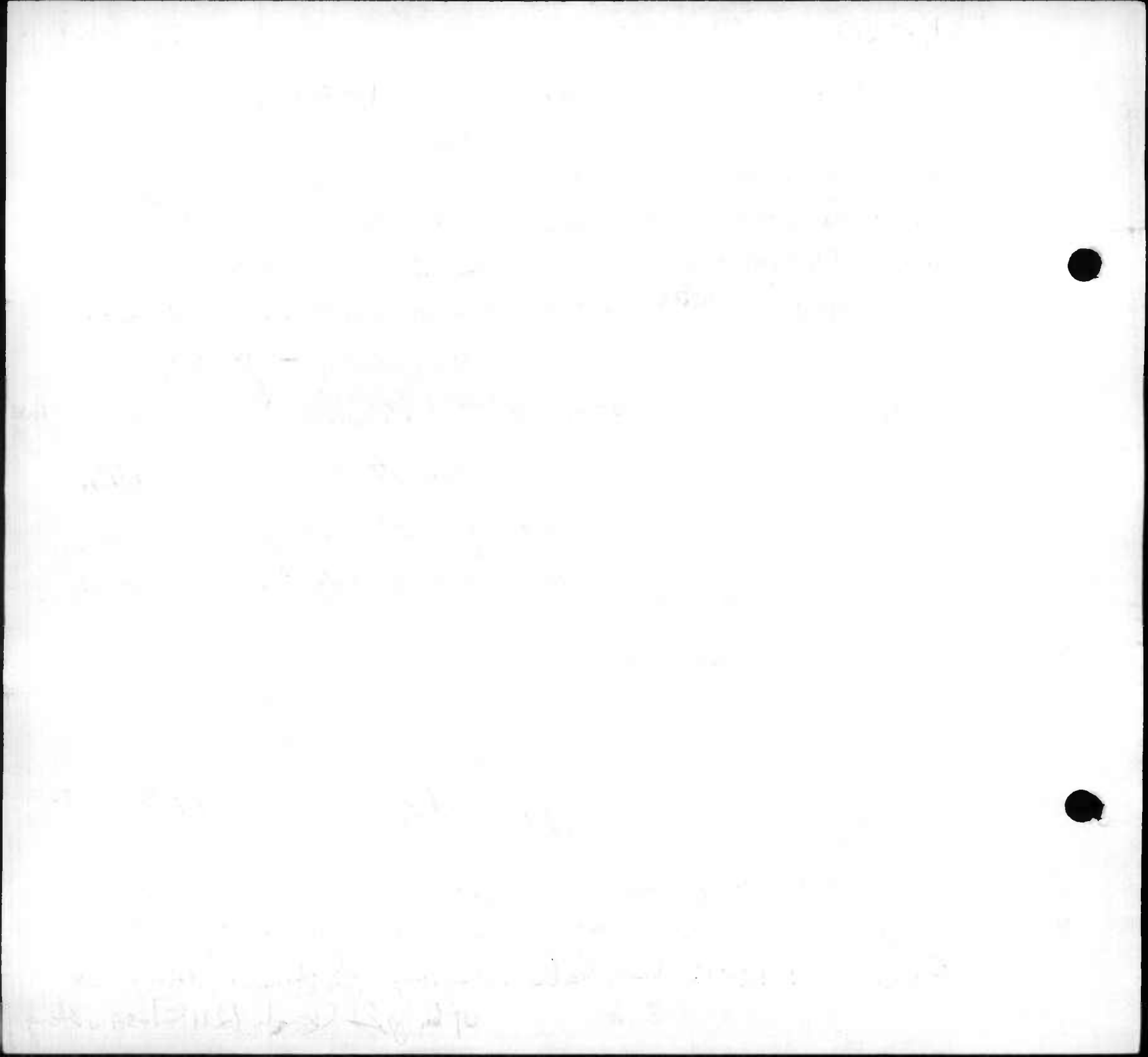
IN SENATE  
 JANUARY 10, 1912  
 REPORT  
 OF THE  
 COMMISSIONERS OF THE LAND OFFICE  
 IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
 MAY 1, 1911  
 ALBANY: J. B. LEECH, STATE PRINTER, 1912.



FUNERAL DIRECTOR: IMPORTANT

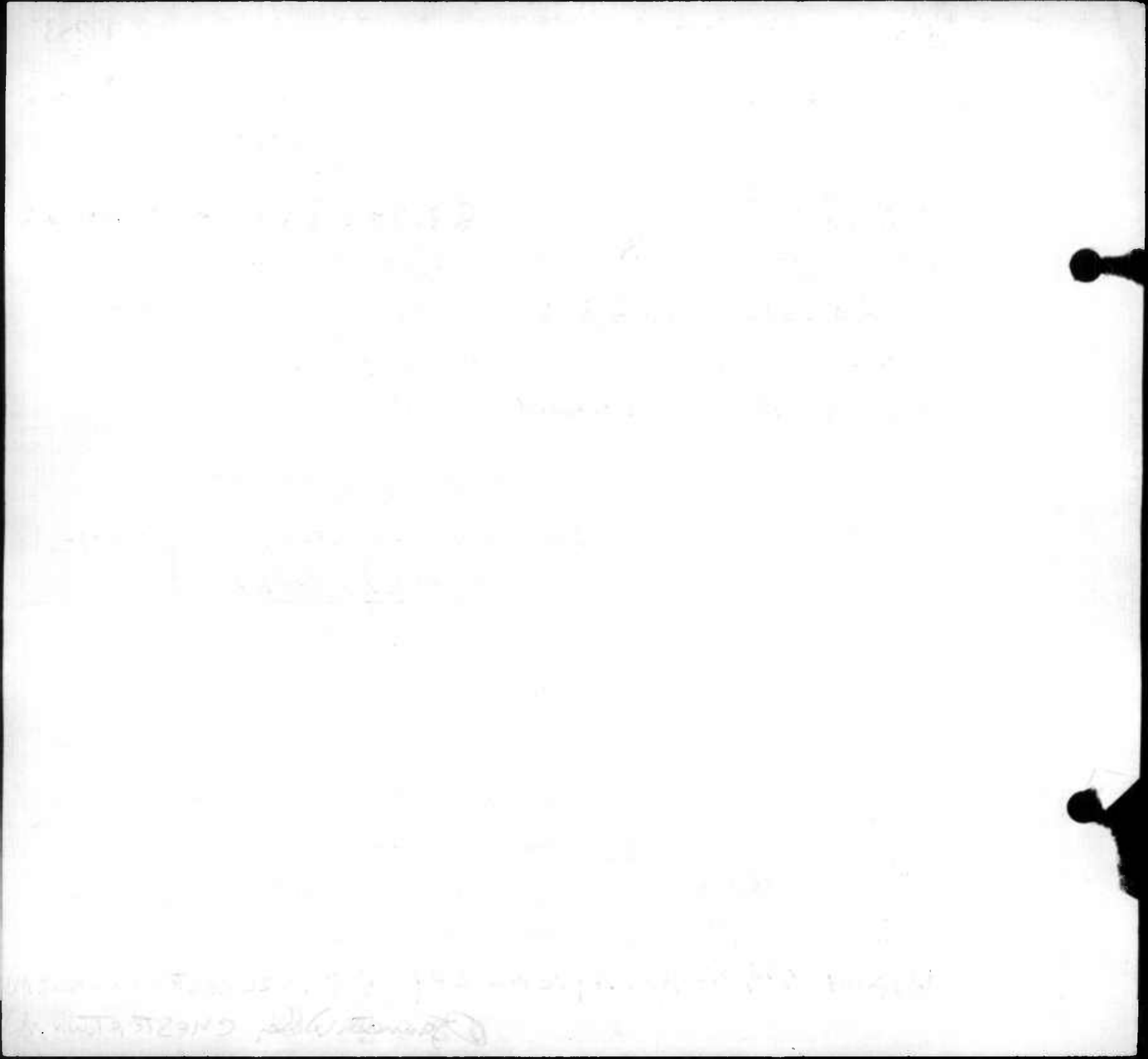
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>K-220</b>      72 00284      BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>72 00284</u></p>	
<p>BIRTH NO. <u>1</u></p>		<p>1. NAME OF DECEASED (Type or Print) <b>KUKUCKA JOSEPH G.</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>1-8-1972 9 10 p.m.</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BOLTON HILL NSG. &amp; CONVALESCENT CENTER 1400 JOHN STREET BALTIMORE, MARYLAND 21217</b></p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>702</b></p>		<p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <b>2437 EAGER STREET</b></p>		<p>5. SEX <b>MALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <b>3-24-85</b> 9. AGE (In years last birthday) <b>86</b> If Under 1 Yr. Months Days If Under 24 Hrs. Min.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b> 11. BIRTHPLACE (State or foreign country) <b>CZECHOSLOVAKIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>JOHN</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>UNKNOWN - Mary</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. <b>218 03 9670</b></p>	
<p>17. INFORMANT <b>MARY MANINOLSKI DAUGHTER</b></p>		<p>ADDRESS <b>3561 LYNDALE AVE</b></p>	
<p>18. <b>412-31</b> CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrothrombosis</b></p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>11/71</b></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arteriosclerosis</b></p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>yes</b></p>	
<p>(C) <b>arteriosclerosis general</b> <b>yes</b></p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> 19 <b>72</b> to <b>1/8</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE </p>		<p>23B. DATE SIGNED <b>1/10/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ALAN H. MAYER</b></p>		<p>23D. ADDRESS <b>212 Read St. Balt Md 21201</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>1-12-72</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Valerie E. Miller, R.S.</b></p>	
<p>25C. FUNERAL DIRECTOR <b>OF Philip St. Church 1211 Chesapeake Ave</b></p>		<p>ADDRESS</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased prior to death; and (6) No physician who pronounced death was in regular attendance on the deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

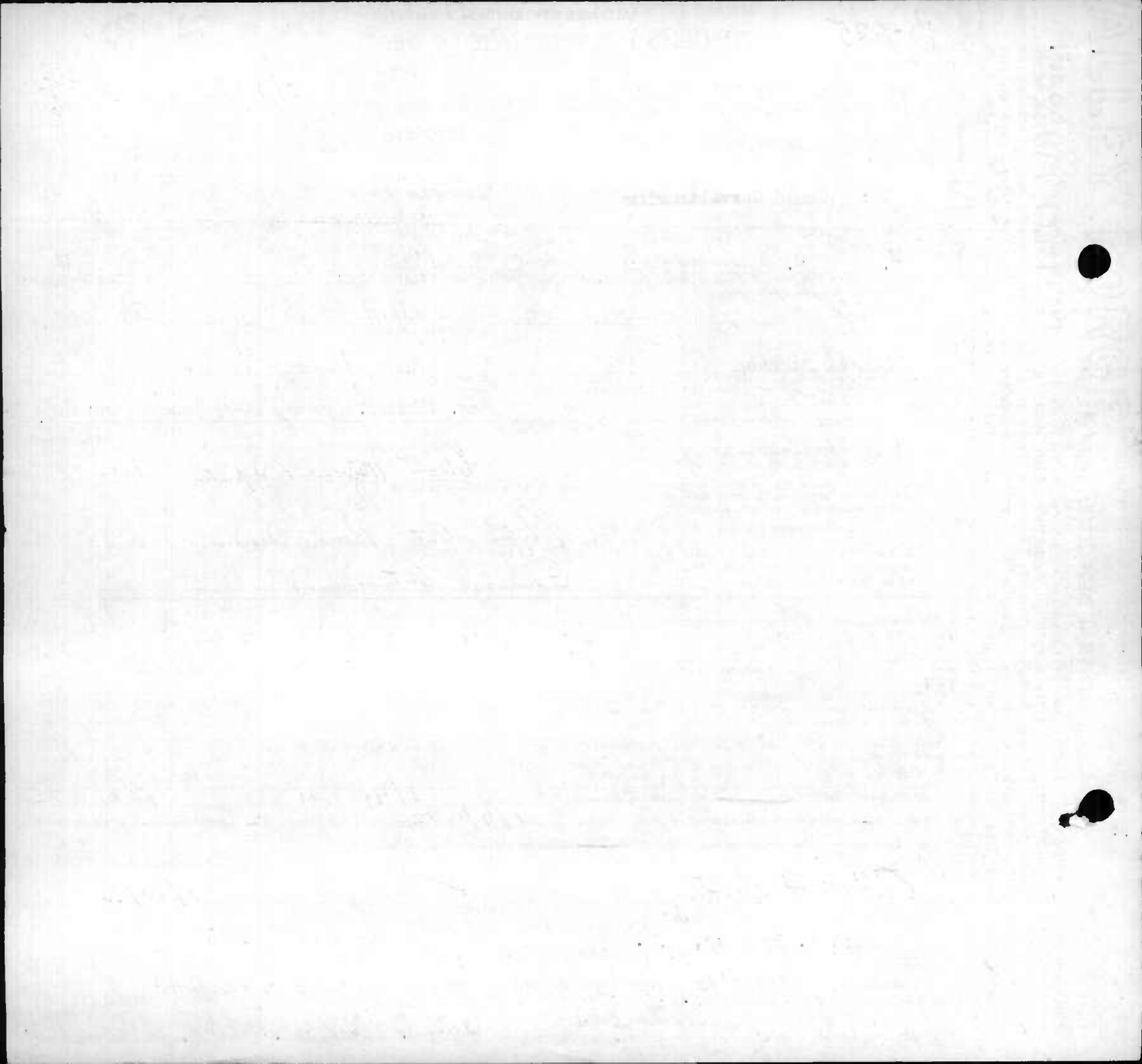
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BRISCOE, Robert S.		1/8/72 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  UNIV. HOSPITAL 38				A. STATE MD	
				B. COUNTY KENT	
				C. CITY OR TOWN OR VILLAGE EASTERN SHORE STATE	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER R.F.D.#2 CHESTERTOWN, MD	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/6/20	9. AGE (In years last birthday) 51
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY VARIOUS		11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WALTER BRISCOE				14. MOTHER'S MAIDEN NAME Grace Olivia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 218-165188		17. INFORMANT CHART	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 150X I prob. (A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) 50p esophagus past neotomy (C) carcinoma of esophagus 5 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 1/3/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of esophagus		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (t) (this hospital) attended the deceased from 12/18/72 to 1/8/72 1972 that (I) (we) last saw the deceased alive on 1/8/72 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE John R. Satterfield Jr. MD				23B. DATE SIGNED 1/8/72	
23C. PHYSICIAN'S NAME (Type) John R. Satterfield, Jr. MD				23D. ADDRESS UNIV. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/15/1972		24C. NAME OF CEMETERY OR CREMATORY ASBURY CEMETERY	
24D. LOCATION R.F.D.#2 CHESTERTOWN KENT. MD		24E. DATE REC'D BY HEALTH DEPT. JAN 12 1972		24F. NAME OF REGISTRAR Charles E. Satterfield	
24G. FUNERAL DIRECTOR Kenneth W. Wagoner		24H. ADDRESS CHESTERTOWN MD		24I. DATE OF DEATH 1/8/72	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00285</u>	
B-625 72 00285		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Margaret Bracken</u>		2. DATE AND HOUR OF DEATH <u>1/8/72</u> <u>9 35</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 The Gould Convalesarium</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2758</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2049 Woodbourne Avenue</u>			
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/1922</u>	9. AGE (In years lost birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Michael Bracken</u>		14. MOTHER'S MAIDEN NAME <u>Annie Tracey</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. Rita P. Conroy 2049 Woodbourne Ave</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Generalized Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic; Chronic Congestive Heart Failure</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this physician</del> ) attended the deceased from <u>3/4/1971</u> to <u>1/8/1972</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>1/7/1972</u> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B Bradley</u>				23B. DATE SIGNED <u>1/10/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley, M.D.</u>				23D. ADDRESS <u>4900 Belair Road 21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/12/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>			
25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u>		25C. FUNERAL DIRECTOR <u>3000 E. Baltimore St.</u>			

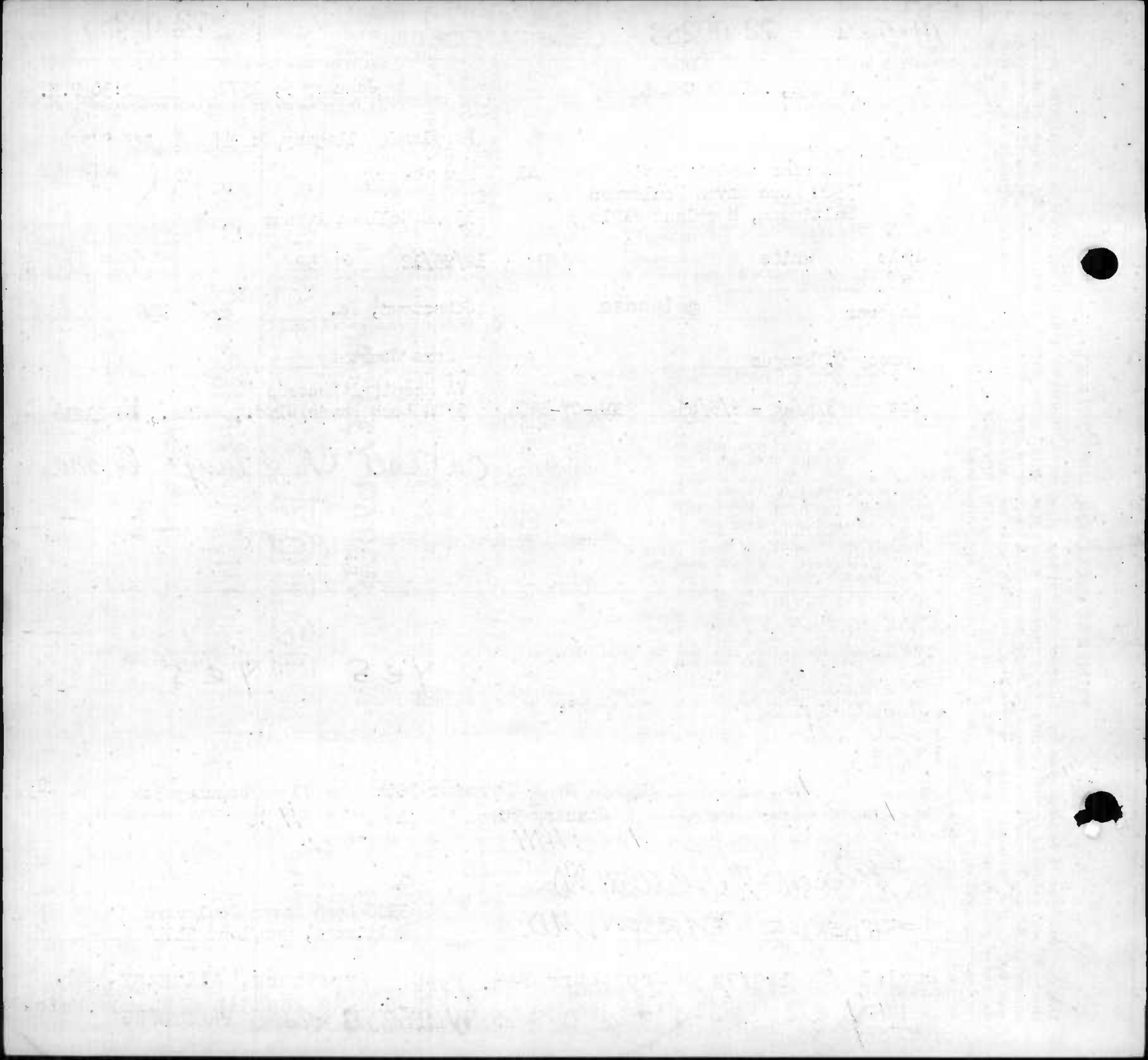




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-522</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00286</u>	
1. NAME OF DECEASED (Type or Print) <u>MANGUS, DORSEY CREAL</u>			2. DATE AND HOUR OF DEATH <u>January 5, 1972</u> <u>2:30 P.M.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Allagany Co</u> C. CITY OR TOWN <u>Frostburg</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>139 E College Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/12</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Celanese</u>	11. BIRTHPLACE (State or foreign country) <u>Johnstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Dorsey C. Mangus</u>			14. MOTHER'S MAIDEN NAME <u>Noma Courtney</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>3/4/42 - 5/5/45</u>		16. SOCIAL SECURITY NO. <u>214-07-4884</u>	17. INFORMANT ADDRESS <u>VA Hospital Records</u> <u>3900 Loch Raven Blvd., Balto., Md 21218</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>162.1</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>		
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>December 30th</u> 19 <u>71</u> to <u>January 5th</u> 19 <u>72</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>January 5th</u> 19 <u>71</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>(did)</u> view the body after death.					
23A. SIGNATURE <u>Frederick H. Pearson, M.D.</u>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK PEARSON, M.D.</u>			23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/9/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Frostburg Mem. Park</u>	24D. LOCATION (City, town, or county) (State) <u>Frostburg, Allegany, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>Robert L. Sowers</u>	25C. FUNERAL DIRECTOR ADDRESS <u>HAFFER-SOWERS FUNERAL HOME</u> <u>60 W. Main.</u> <u>Frostburg</u>		



B-640

72 00287

BALTIMORE CITY HEALTH DEPARTMENT

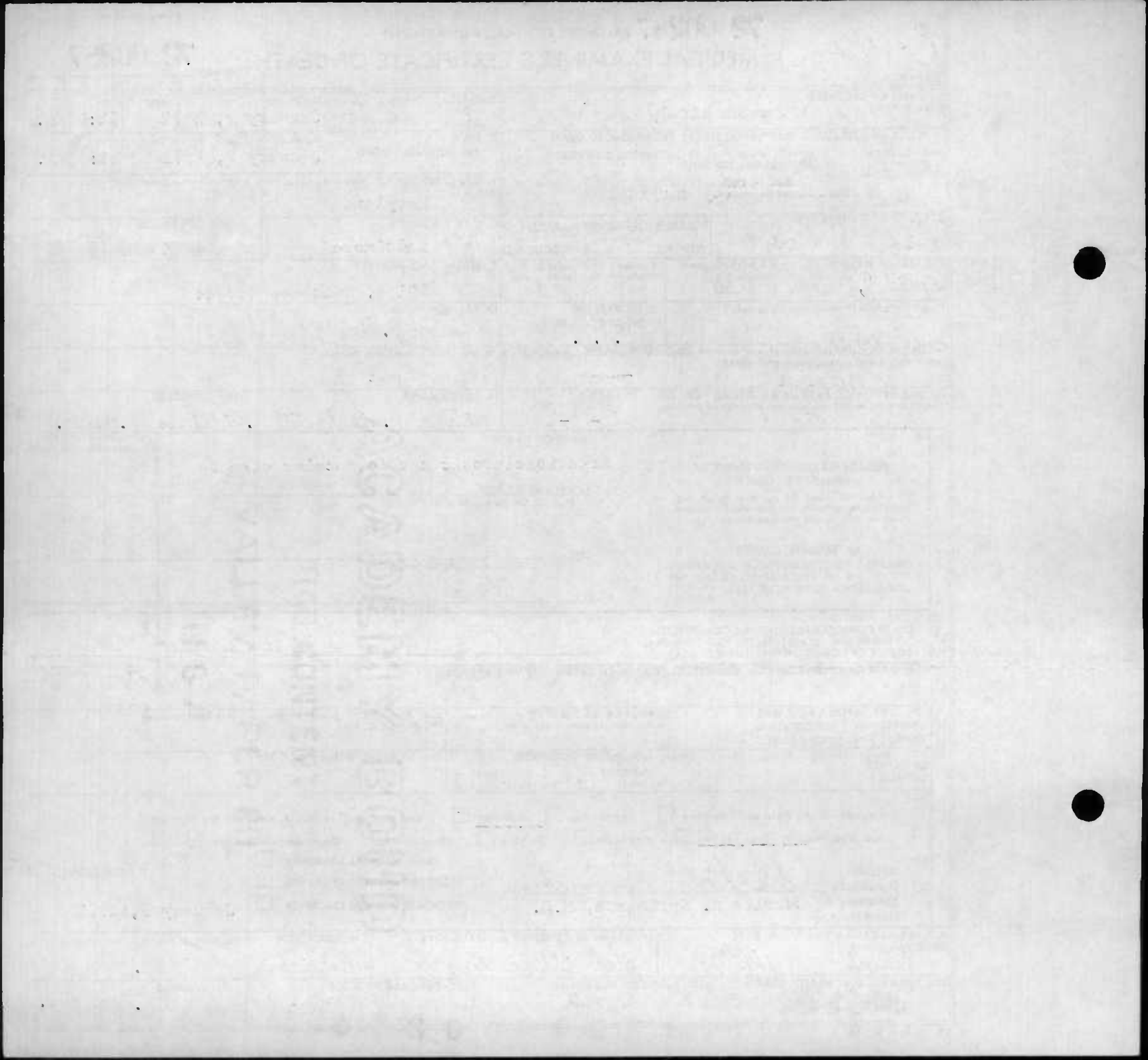
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00287

BIRTH NO.

REG. NO.

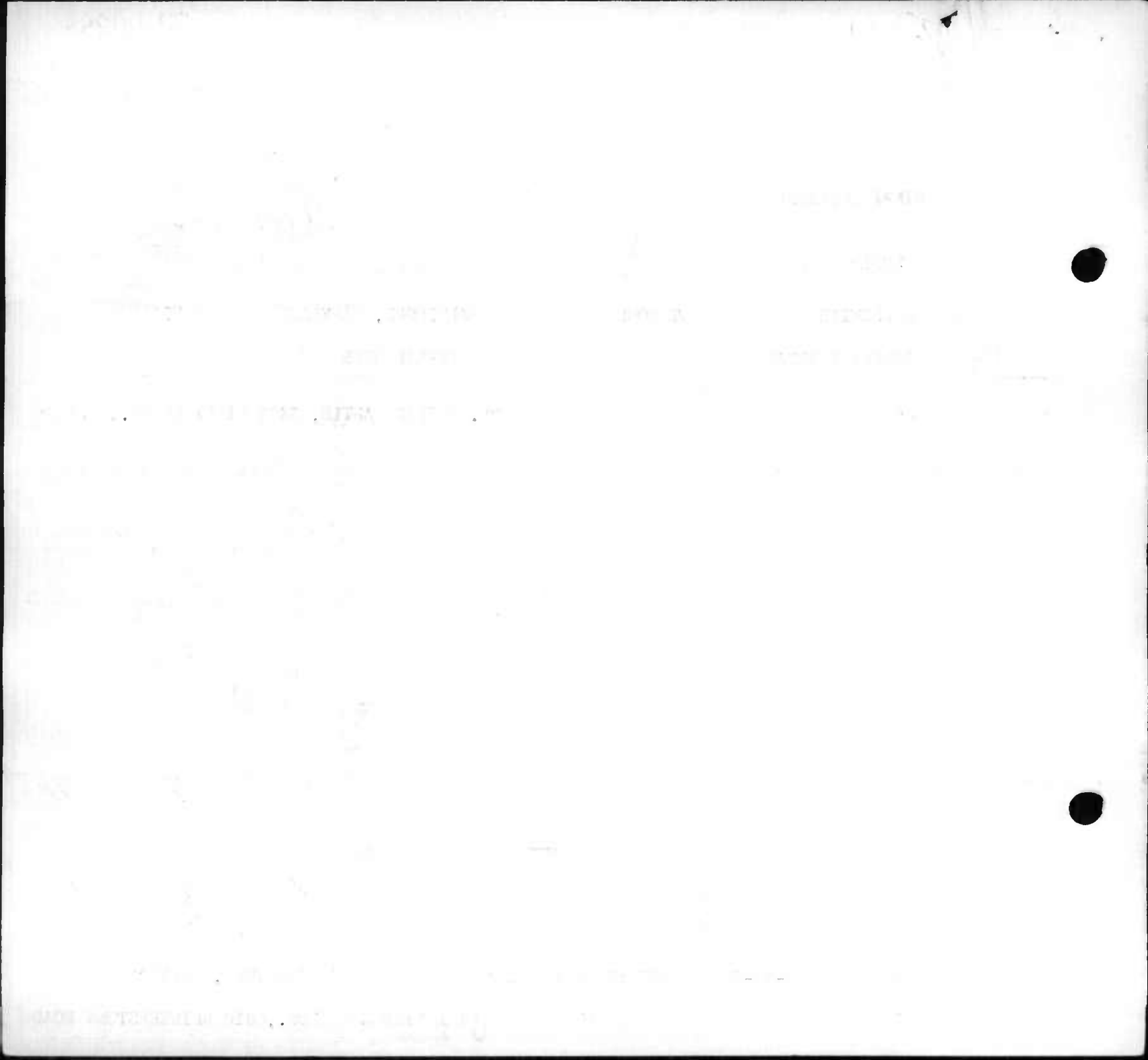
1. NAME OF DECEASED (Type or Print) Samuel Birely		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year January 9, 1972		Hour 12:05 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year January 9, 1972		Hour 12:05 A.M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2403				
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH April 4, 1921		10. AGE (In years lost birthday) 56	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel J. Birely		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		14B. KIND OF BUSINESS OR INDUSTRY -----		15. MOTHER'S MAIDEN NAME Margaret Long
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		17. SOCIAL SECURITY NO. 215-18-9286		18. INFORMANT Mildred L. Birely
19. 412.4 I		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) -----				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 9, 1972				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/12/72	24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) Baltimore		(State) Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCully Funeral Homes
				ADDRESS 130 E. Fort Ave.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-340		72 00288		BALTIMORE CITY HEALTH DEPARTMENT		72 00288	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Theresa Taetle</i>				2. DATE AND HOUR OF DEATH <i>January 9-72 4:00 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Sinai Hospital</i> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>SINAI HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3408 Midfield Rd</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>CAUCASIAN</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-23-06</i>	9. AGE (In years last birthday) <i>65</i>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>SAMUEL SHERMAN</i>				14. MOTHER'S MAIDEN NAME <i>CARRIE HESS</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. PHILIP TAETLE, 3408 MIDFIELD RD., #21208</i>			
18. <i>582X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Uremic Acidosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Renal Failure</i> (C) <i>Sensitivity</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-29</i> 19 <i>71</i> to <i>1-9</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1-9</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>1-9-72</i>		23C. PHYSICIAN'S NAME (Type) <i>Manfous</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>1-10-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>BETH EL MEMORIAL PARK</i>	
24D. LOCATION (City, town, or county) (State) <i>RANDALLSTOWN, MARYLAND</i>				25A. DATE REC'D BY HEALTH DEPT. <i>JAN 12 1972</i>			
25B. NAME OF REGISTRAR <i>[Signature]</i>				25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00289</span>	
BIRTH NO. <span style="float: left;">H-630</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ELSIE HERWOOD</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 7, 1972</b> <b>7:55 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3705 N. CHARLES STREET</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1201</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3705 N. CHARLES STREET #21218</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>65</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>SAMUEL BLUM</b>			14. MOTHER'S MAIDEN NAME <b>FANNIE GOLDSTEIN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>MR. WILLIAM P. HERWOOD, 3705 N. CHARLES ST. #21218</b>		
18. <b>1579 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Carcinoma of Pancreas 2-3 Months</b> <b>Liver Metastases</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Months</b>		
19A. DATE OF OPERATION <b>Dec 6-7-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exploratory</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 1971</b> to <b>1/7/72</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>1/7/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sol Smith</b>				23B. DATE SIGNED <b>1/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SOL SMITH</b>				23D. ADDRESS <b>6810 PARK HEIGHTS AVENUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-9-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, 220</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

DATE: 1/1/52

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover  
SUBJECT: [illegible]

RE: [illegible]

RE: [illegible]  
[illegible]  
[illegible]

RE: [illegible]  
[illegible]  
[illegible]

RE: [illegible]

RE: [illegible]  
[illegible]

RE: [illegible]

1/1/52  
1/1/52

1/1/52

RE: [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
6-435 72 00290					REG. NO. 72 00290				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) Rachel Goldman (KLEIN)					2. DATE AND HOUR OF DEATH 1/7/72 9:15 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 Good Samaritan Hospital Loch Raven Blvd. Baltimore, Md.					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Baltimore County 2717				
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 12/28/XX 97 9. AGE (In years last birthday) 74 XXXX				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10B. KIND OF BUSINESS OR INDUSTRY AT HOME				
11. BIRTHPLACE (State or foreign country) ENGLAND					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Hyman Freedman					14. MOTHER'S MAIDEN NAME Betsy Solomon				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XXXXXX NO					16. SOCIAL SECURITY NO. 220-54-7252				
17. INFORMANT MR. HARRY KLEIN, 18 GAYLORD ROAD TRUMBILL, CONN. 06611					ADDRESS				
18. CAUSE OF DEATH I 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Colon (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Mon. 2 yrs.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD									
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (this hospital) attended the deceased from 12/20/71 to 1/7/72 that (we) last saw the deceased alive on 1/7/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul J. Edgar M.D. DEGREE					23B. DATE SIGNED 1/7/72				
23C. PHYSICIAN'S NAME (Type) Paul J. Edgar M.D.					23D. ADDRESS Good Sam. Hospital Balto.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 1-9-72				
24C. NAME OF CEMETERY or CREMATORY MIKRO KODESTH-BETH ISRAEL					24D. LOCATION BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972					25B. NAME OF REGISTRAR				
25C. FUNERAL DIRECTOR GOL. LEVINSON & BROS., 6010 REISTERSTOWN ROAD					ADDRESS				

AMAL 24 JUL 67

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MR. HARRY ELKIN, 10 DAYTON ST.  
THUNDERBOLT, OHIO 43081

AMAL 24 JUL 67

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. <span style="float: right;">2 00291</span>
B-452 72 00291										
BIRTH NO. <span style="float: right;">1</span>					CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>JENNIE BLANK</b>					2. DATE AND HOUR OF DEATH <b>JANUARY 6, 1972</b> <span style="float: right;">9 A. M.</span>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CONCORD HOUSE, APT. 503 2500 W. BELVEDERE AVENUE</b>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2500 W. BELVEDERE AVENUE, APT. 503</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-8-1889</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>BORACK RODMAN</b>					14. MOTHER'S MAIDEN NAME <b>SARA ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MR. ALBERT BLANK, 10 SUGARLOAF CT., APT. 201 #21209</b>					
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Myocardial Infarction sudden</b> (B) <b>HACVD</b> (C) <b>8 year</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>January 1964</b> to <b>January 1972</b> , that (I) (we) last saw the deceased alive on <b>December 15 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Cecil Rudner</b> <span style="float: right;">MD</span>					23B. DATE SIGNED <b>1-7-72</b>			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) <b>CECIL RUDNER</b>					23D. ADDRESS <b>6821 REISTERSTOWN ROAD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>1-9-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>			ADDRESS <b>6010 REISTERSTOWN ROAD</b>		

2000 N. BROADWAY AVENUE

2000 N. BROADWAY AVENUE

2-2-1988

AT 10:00

AT 10:00

AT 10:00

AT 10:00

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00292	
C-620				72 00292	
BIRTH NO.				72 00292	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CROSS, LOUIS ELMER			JANUARY 7, 1972 2:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8131 MAIN STREET		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 08/28/07	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WORKER		10B. KIND OF BUSINESS OR INDUSTRY TEXTILE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HOWARD MARSHALL CROSS		14. MOTHER'S MAIDEN NAME ISABELL SULLIVAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W 2		16. SOCIAL SECURITY NO. 217-05-4964		17. INFORMANT WILKENS AVES BALTO MD 21229 ST AGNES HOSPITAL RECORDS CATON &	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 471X17303.2 CAUSE OF DEATH Bilateral Bronchopneumonia Influenza Chronic Alcoholism			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from JANUARY 4 19 72 to JANUARY 7 19 71 that XIX (we) last saw the deceased alive on JANUARY 7 19 71 and that in XIX (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rahman Karimi M.D.				23B. DATE SIGNED 11/7/72	
23C. PHYSICIAN'S NAME (Type) RAHMAN KARIMI M.D.				23D. ADDRESS CATON & WILKENS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-10-72		24C. NAME OF CEMETERY OR CREMATORY ST. John's Cem.	
24D. LOCATION (City, town, or county) (State) Ellicott City Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972			
25B. NAME OF REGISTRAR SQUAD. Patrick Hume		25C. FUNERAL DIRECTOR Ellicott City Md. 21240			

101

11-21-20

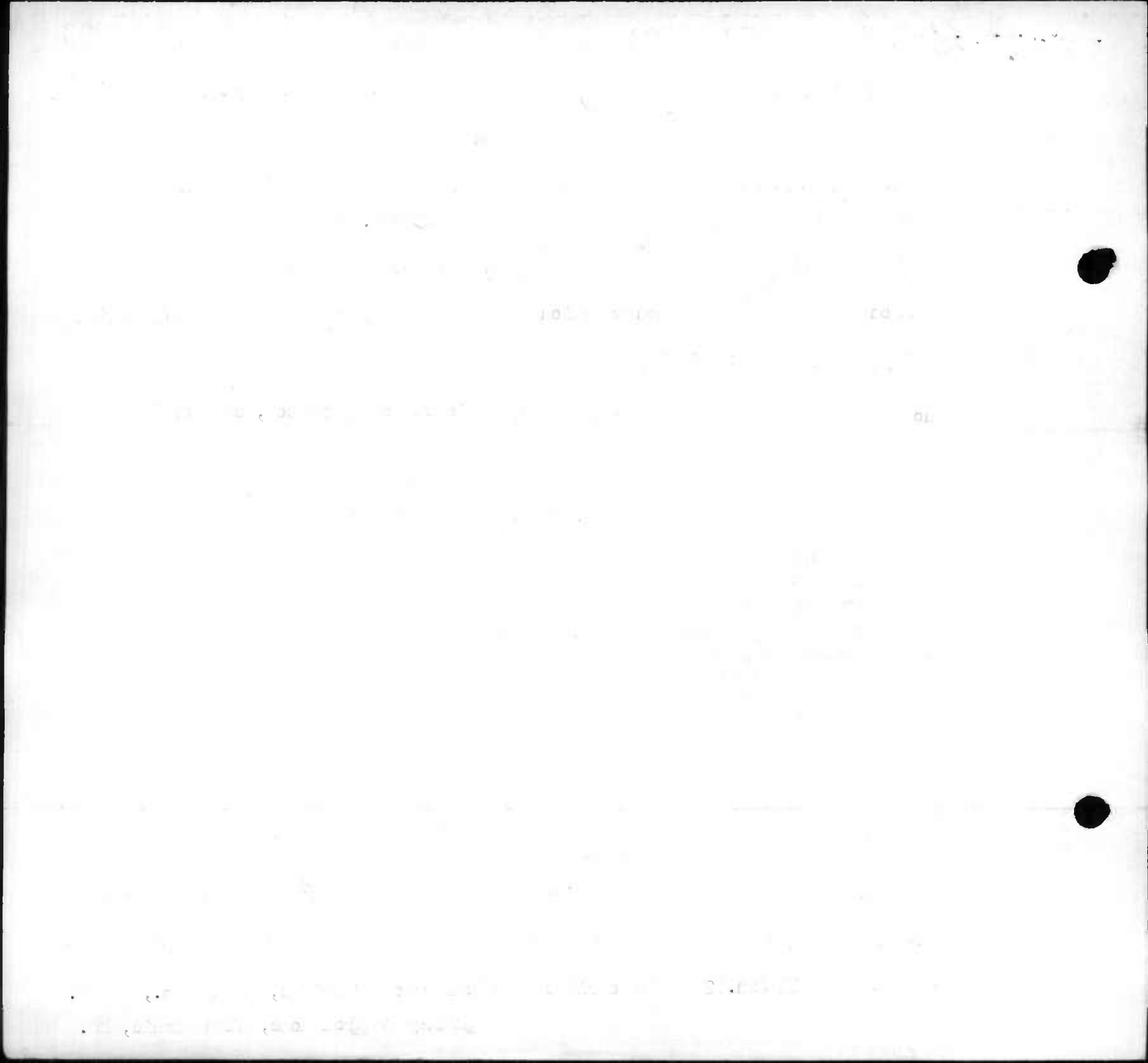
1991-1992



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

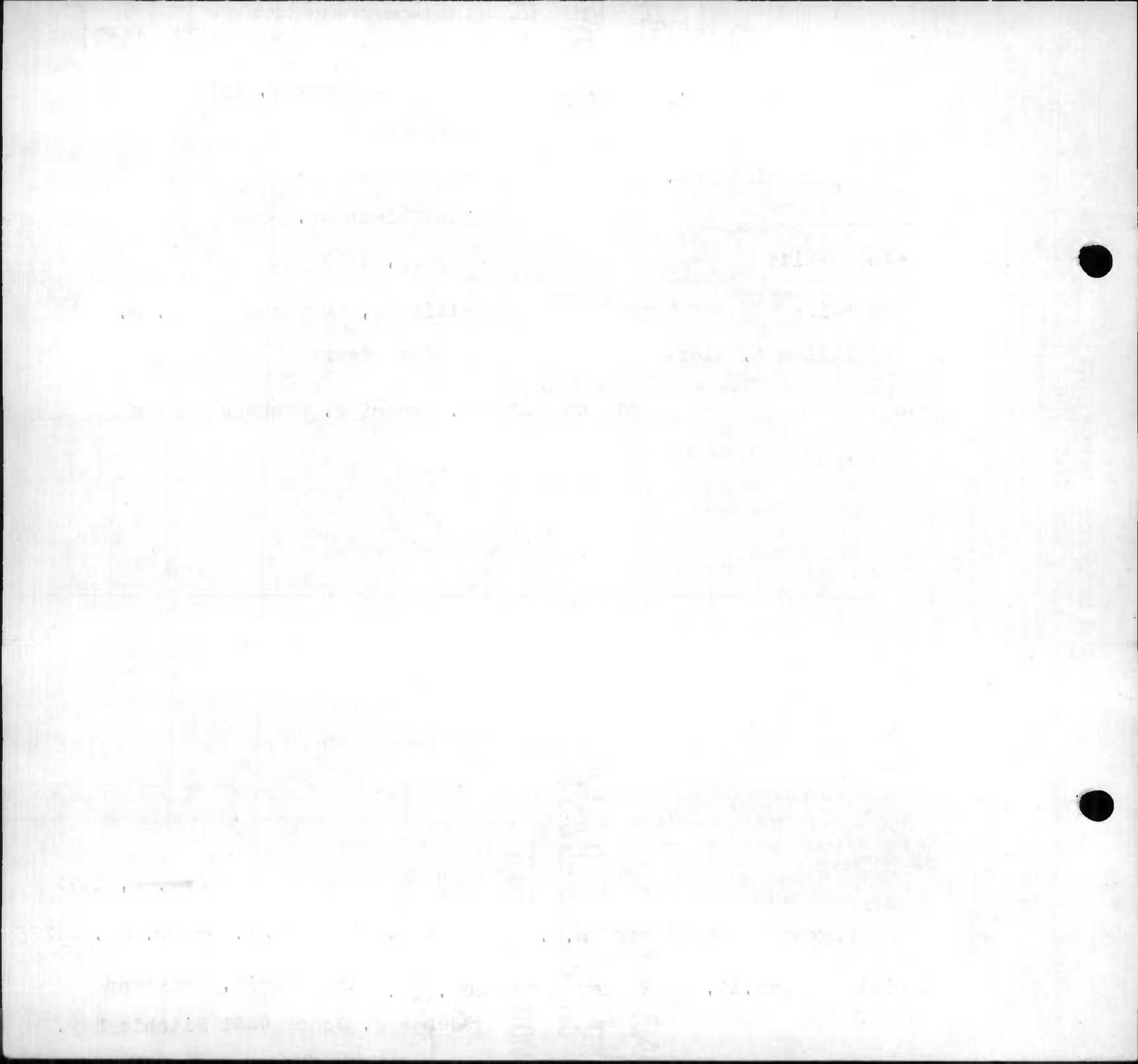
<p><b>G-613</b>      <b>72 00293</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>72 00293</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>GRAFTON HARRY E</b></p>		<p><b>Jan. 9, 1972</b>   <b>1:20 A.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission)</p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)</p> <p><b>SOUTH BALTIMORE GENERAL HOSPITAL</b></p>		<p><b>MARYLAND ANNE ARUNDEL</b>      <b>5200</b></p>	
<p><b>5. SEX</b>      <b>6. RACE</b></p> <p><b>M</b>      <b>W</b></p>		<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><b>Mason</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><b>MARYLAND</b></p>	
<p><b>13. FATHER'S NAME</b></p> <p><b>QUILLA GRAFTON</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><b>BESSIE BOSLEY</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>no</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p> <p><b>214-12-2572</b></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>153.9 I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>17. INFORMANT</b>      <b>ADDRESS</b></p> <p><b>Violet Young Grafton, same as 4</b></p>	
<p><b>19A. DATE OF OPERATION</b></p> <p><b>0</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p> <p>(APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/>      Not While At Work <input type="checkbox"/></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan. 8</b> <b>1972</b> <b>to</b> <b>Jan. 9</b> <b>1972</b></p> <p><b>that (I) (we) last saw the deceased alive on</b> <b>Jan. 9</b> <b>1972</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>23A. SIGNATURE</b></p> <p><b>NHL - de Lara</b>      <b>H.D. DEGREE</b></p>		<p><b>23B. DATE SIGNED</b></p> <p><b>1-9-72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><b>NORA LICERALDE - DE LARA</b>      <b>H.D. DEGREE</b></p>		<p><b>23D. ADDRESS</b></p> <p><b>SOUTH BALTD. GEN. HOSPITAL</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p><b>BURIAL</b></p>		<p><b>24B. DATE</b></p> <p><b>11 Jan. 72</b></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b></p> <p><b>Meadowridge Memorial Park</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><b>Elkridge, Howard Co., Md.</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><b>JAN 12 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b></p> <p><b>Robert E. Taylor, M.D.</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b></p> <p><b>Griley Funeral Home, Glen Burnie, Md.</b></p>		<p><b>ADDRESS</b></p>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

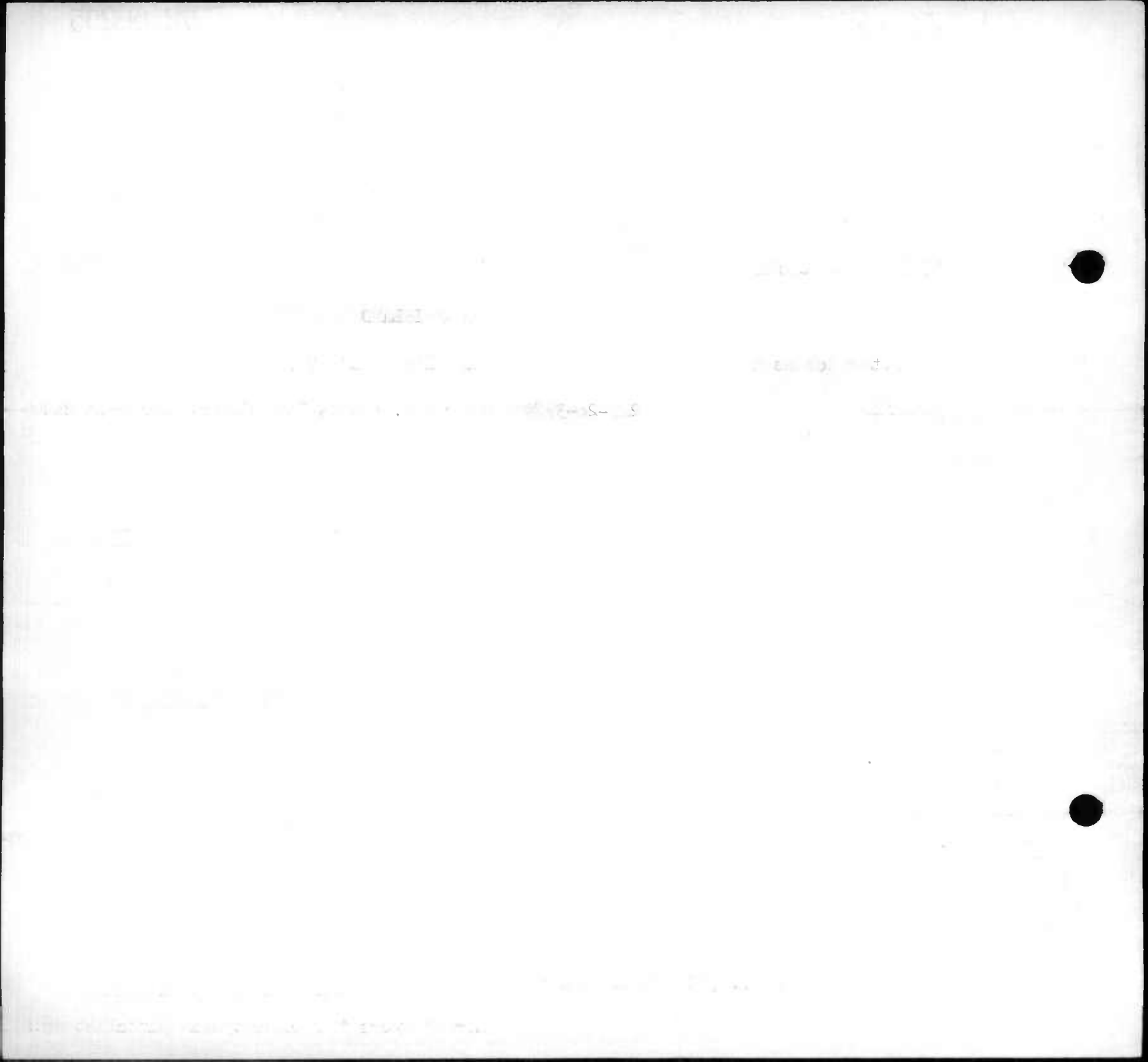
BIRTH NO. <b>N-200</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00294</b>	
1. NAME OF DECEASED (Type or Print) <b>Loretta E. Neuhaus</b>			2. DATE AND HOUR OF DEATH <b>January 7, 1972</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3807 Ninth St.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2544</b>		
5. SEX <b>Female</b>			6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>July 23, 1913</b>			9. AGE (In years last birthday) <b>58</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			13. FATHER'S NAME <b>William A. Slert</b>		
14. MOTHER'S MAIDEN NAME <b>Louise Reese</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>215 03 5170</b>			17. INFORMANT <b>Mr. Ernest G. Neuhaus</b> ADDRESS <b>Same</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>1-7-1957</b> 19 to <b>1-7-</b> 1972, that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Eugene Schnitzer</b> DEGREE 23B. DATE SIGNED <b>Jan. 8, 1972</b> 23C. PHYSICIAN'S NAME (Type) <b>Eugene Schnitzer M.D.</b> DEGREE 23D. ADDRESS <b>3904 S. Hanover St. Balto. Md. 21225</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>Jan. 10, 1972</b> 24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Mem. pk.</b> 24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b> 25A. DATE REC'D BY HEALTH DEP. <b>JAN 12 1972</b> 25B. NAME OF REGISTRAR <b>George J. Gonce</b> 25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hwy.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>K-653</b>      72 00295</p> <p style="text-align: center;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <u>72 00295</u></p>	
<p><b>BIRTH NO.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="text-align: center;">1/7/72 11 30 P.M.</p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print)</p> <p style="text-align: center;">Angelina Krantz</p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p style="text-align: center;">Md Baltimore 5300</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p style="text-align: center;">Full Name of Hospital or Institution (If not in hospital or institution, give street address or location) Bon Secours Hospital 2025 W. Fayette St Baltimore, Md 21223</p>		<p><b>5. CITY OR TOWN</b> <b>D. INSIDE CITY LIMITS?</b></p> <p style="text-align: center;">Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>6. SEX</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Female Caucasian WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <b>9. AGE</b> (In years last birthday) 40 8/19/31</p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife</p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>12. CITIZEN OF WHAT COUNTRY?</b> RHODE ISLAND USA</p>	
<p><b>13. FATHER'S NAME</b> Peter Robinson</p>		<p><b>14. MOTHER'S MAIDEN NAME</b> Angeline (Radloff)</p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>ADDRESS</b> 217-26-3989 George W. Krantz 3606 Forest Hill Road 21207</p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Invasive GI hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: Esophageal varices (C) DUE TO, OR AS A CONSEQUENCE OF: Alcoholic cirrhosis</p>	
<p><b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 2</p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> Yes</p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) 21D. TIME OF INJURY (APPROX.)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?</p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from January 2, 1972 to January 7, 1972 that (I) (we) last saw the deceased alive on January 7, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> Thien Thitivarana M.D. DEGREE</p>		<p><b>23B. DATE SIGNED</b> January 7, 72.</p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Typo) THIEN THITIVARANA M.D. DEGREE</p>		<p><b>23D. ADDRESS</b> BON SECOURS HOSPITAL</p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> BURIAL</p>		<p><b>24B. DATE</b> <b>24C. NAME of CEMETERY or CREMATORY</b> <b>24D. LOCATION</b> (City, town, or county) (State) Jan. 10, 72 Woodlawn Cemetery Woodlawn Baltimore Maryland</p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>25B. NAME OF REGISTRAR</b> <b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> JAN 12 1972 Loring Byers 8728 Liberty Road Randallstown, Md.</p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00296		REG. NO. 72 00296	
L-260		72 00296		CERTIFICATE OF DEATH		+	
1. NAME OF DECEASED (Type or Print) <i>Dorothy Elizabeth Leager</i>				2. DATE AND HOUR OF DEATH <i>Jan. 8, 1972</i> <i>8:15 p.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>40 St. Agnes Hospital</i> <i>900 S. Caton Ave</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>2201 Smith Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 11, 1919</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Factory worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Russel H. Deardon</i>				14. MOTHER'S MAIDEN NAME <i>Fleta Folk</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>164-14-2883</i>		17. INFORMANT <i>Husband</i> <i>Clifton G. Leager</i>		ADDRESS <i>2201 Smith Ave. 21227</i>	
18. <i>4/10-9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Inf.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>7 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1950</i> to <i>Jan 8 1972</i> , that (I) (we) last saw the deceased alive on <i>Jan 8 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Paul Schonfeld</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/10/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Paul Schonfeld</i>				23D. ADDRESS <i>2201 Annapolis Rd.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/12/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Fernwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Fernwood, Pennsylvania</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 12 1972</i>		25B. NAME OF REGISTRAR <i>Rose Elizabeth</i>		25C. FUNERAL DIRECTOR <i>Mc Eully F. L.</i> ADDRESS <i>237 Patapsco Ave. 21225</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00297

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT J. GRAVES</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>January</b> Day <b>7</b> Year <b>1972</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3711 Wilkens Ave.</b>				3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>7</b> Year <b>1972</b> 8:05 P.M.	
6. SEX <b>Male</b>				7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-19-1909</b>				10. AGE (In years last birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard W. Graves</b>				14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2557</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Nellie Sadler</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>216-10-3732</b>				18. INFORMANT ADDRESS <b>Mrs. Nellie K. Frame, 3711 Wilkens Ave. 21229</b>	
19. <b>412.4 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic cardiovascular disease</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 20A. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <b>Yes</b>					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-8-72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-11-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>			
25B. NAME OF REGISTRAR <b>Howard H. Hubbard, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



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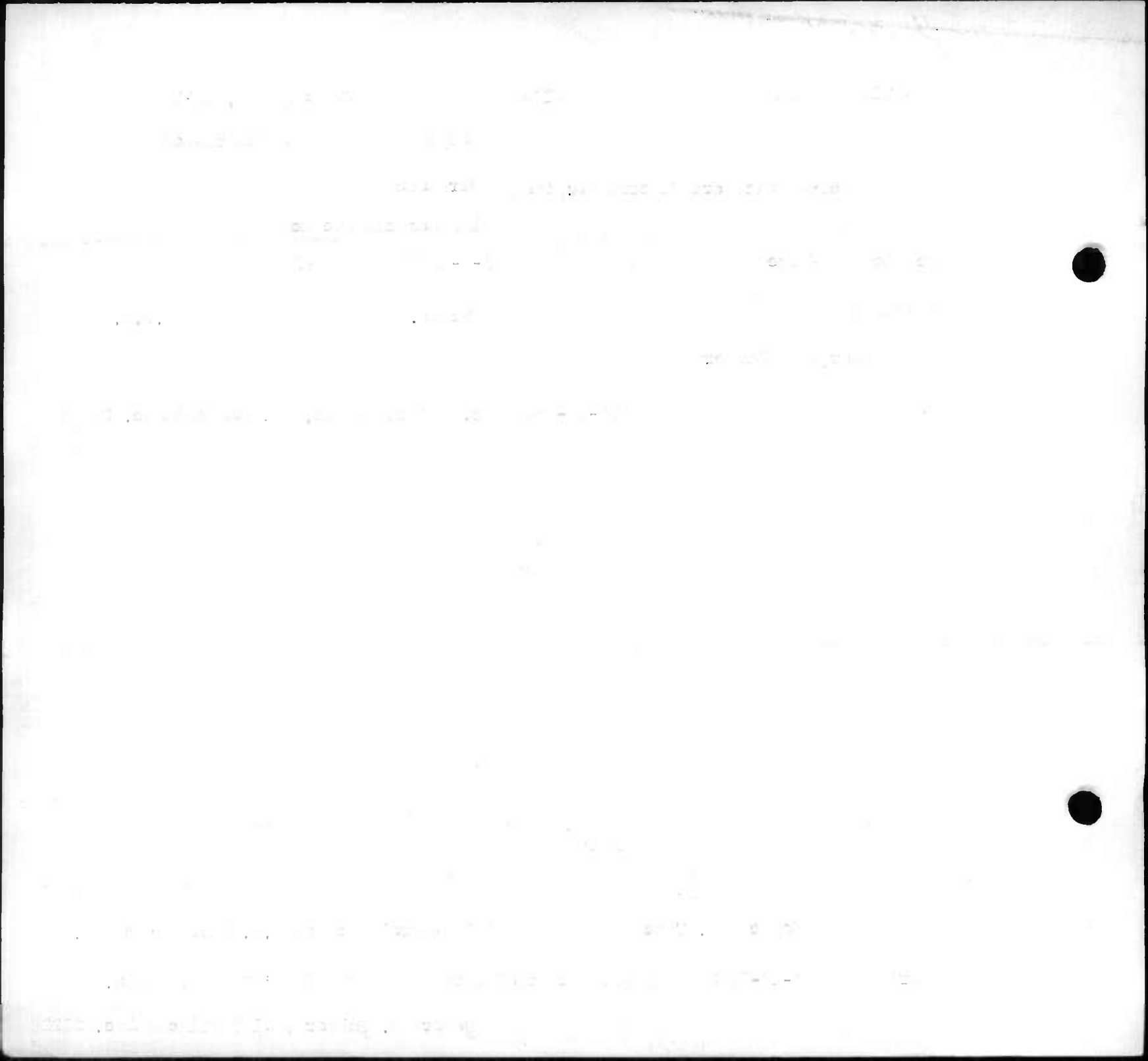
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

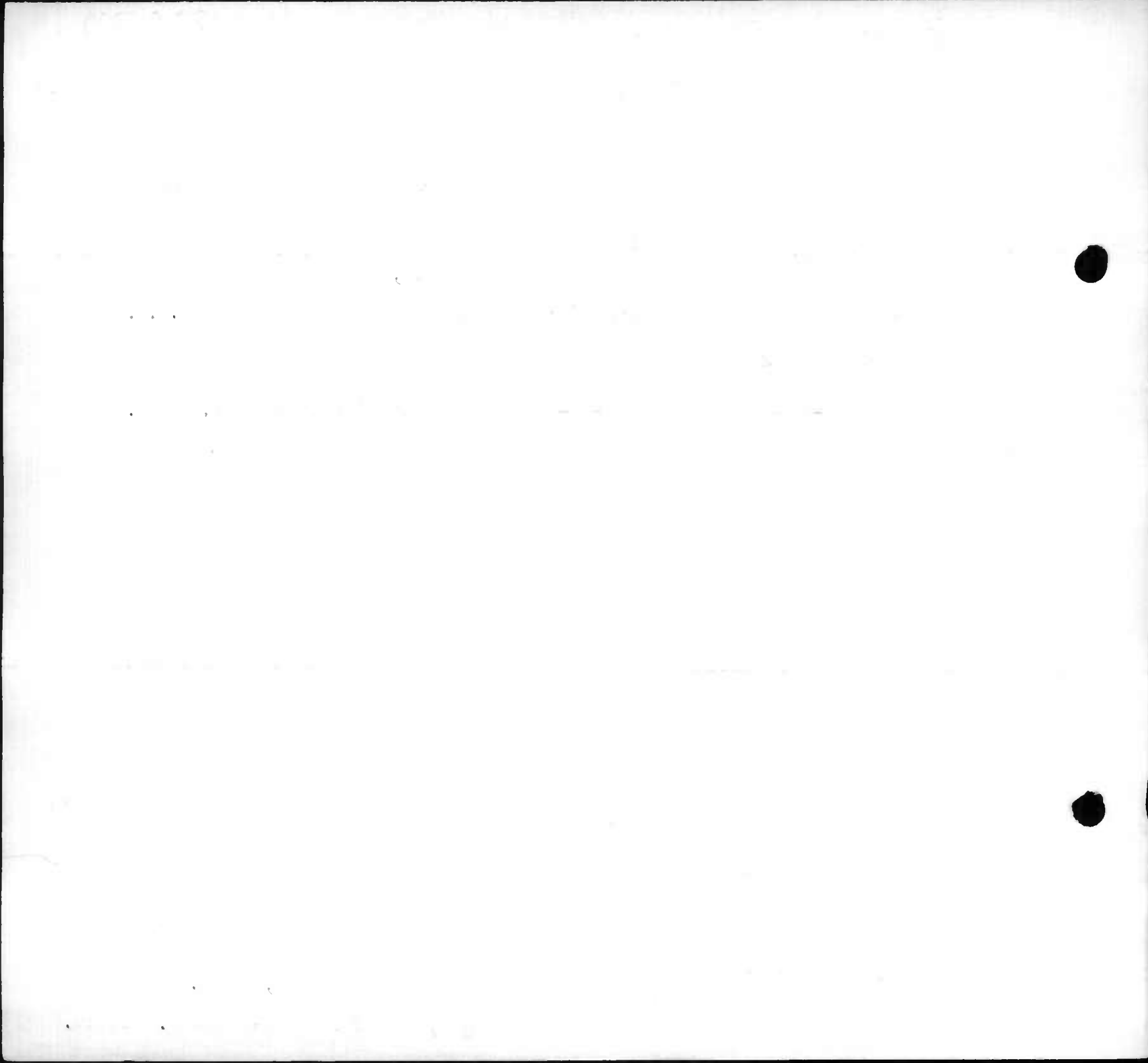
BIRTH NO. <u>H-260</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00298		72 00298	
1. NAME OF DECEASED (Type or Print) <b>BESSIE MAE HEISER</b>				2. DATE AND HOUR OF DEATH <b>January 8, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> <b>5200</b>			
				C. CITY OR TOWN <b>Ferndale</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>105 Caswell Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-8-1906</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>George Becker</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>179-10-8849</b>		17. INFORMANT ADDRESS <b>Mr. Oliver Heiser, 105 Caswell Ave. 21061</b>	
18. <b>250.91</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetes Mellitus</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> 19 to <b>Jan 3</b> 19 <b>72</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>1-3</b> 19 <b>72</b> and that (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Wayne B. Tate</b>				23B. DATE SIGNED <b>1/8/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Wayne B. Tate</b>	
23D. ADDRESS <b>108 Central Avenue, S.W. Glen Burnie, Md.</b>				23E. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		23F. ADDRESS <b>4107 Wilkens Ave. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-13-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Sky View Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Schuylkill County, Penna.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Tate, Jr.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>	



FUNERAL DIRECTOR: IMPORTANT

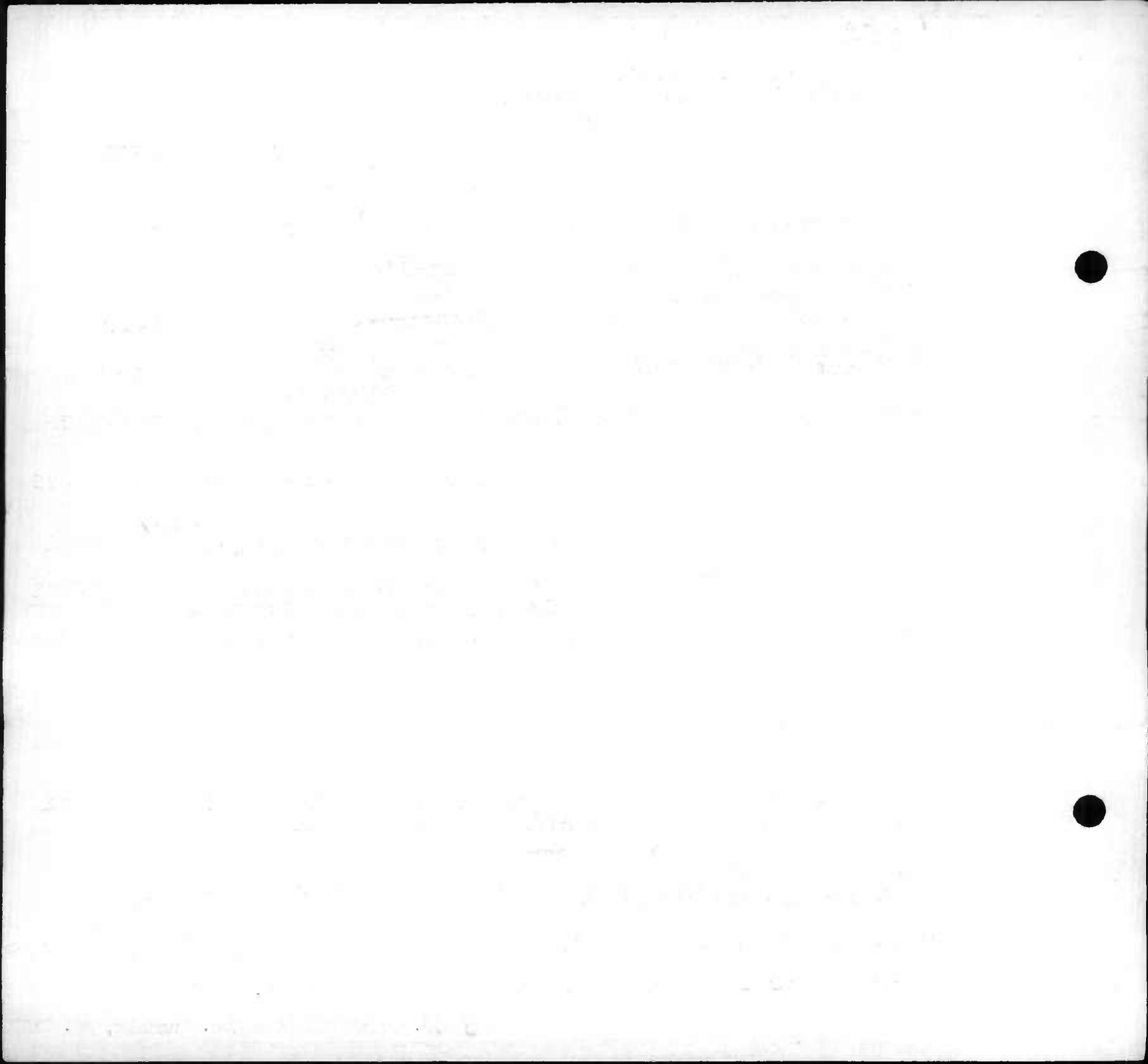
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>D-600</b>      72 00299      BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 72 00299</p>			
<p>BIRTH NO. <span style="float: right;">1</span></p> <p>1. NAME OF DECEASED (Type or Print) <b>Antoinette Dorr</b></p>		<p>2. DATE AND HOUR OF DEATH <b>1/10/72 3:30 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1504 Battery Avenue</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2404</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1504 Battery Avenue</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>August 14, 1936</b></p>
<p>9. AGE (in years last birthday) <b>35</b></p>		<p>10. UNDER 1 Yr. Months: Days: Hours: Min.</p>	<p>11. UNDER 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Office supplies</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>Albert McManus</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Marie Schafer</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b></p>		<p>16. SOCIAL SECURITY NO. <b>212-34-4361</b></p>	<p>17. INFORMANT ADDRESS <b>Frank Dorr 1504 Battery Ave. Balto.</b></p>
<p>18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <b>Carcinomatosis</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>origin NOT found</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Months</b></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>11/9/72</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Splenoctomy laparotomy</b></p>	<p>20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>10/22</b> 19<b>71</b> to <b>1/10</b> 19<b>72</b> that (I) (we) last saw the deceased alive on <b>1/9</b> 19<b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>George S. Tan M.D.</b></p>		<p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	<p>23B. DATE SIGNED</p>
<p>23C. PHYSICIAN'S NAME (Type) <b>George S. Tan</b></p>		<p>23D. ADDRESS <b>4306 Belle Grove Rd Balto. 21225</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>1/13/72</b></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b></p>	<p>25B. NAME OF REGISTRAR <b>Robert F. Taylor M.D.</b></p>	<p>25C. FUNERAL DIRECTOR ADDRESS <b>McCall's Funeral Homes 130 E. Fort Ave.</b></p>	



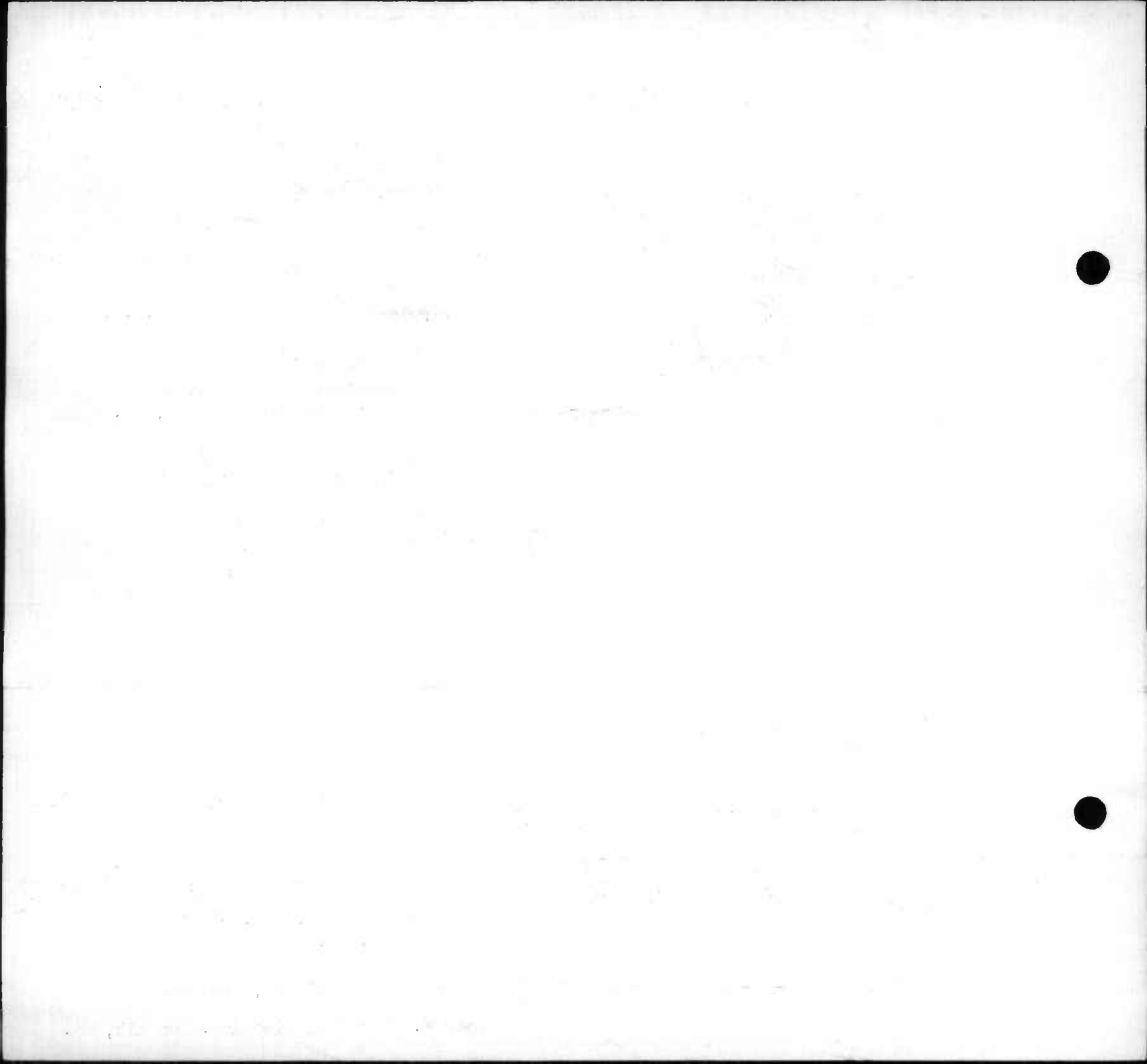
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-552 72 00300		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00300 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Helen M. Cunningham</u>		2. DATE AND HOUR OF DEATH <u>7 JAN 1972 17:55 A. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>45 GOOD SAMARITAN HOSPITAL</u>		E. STREET AND NUMBER <u>806 JAYDEE AVENUE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1912</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>WILLIAM COMPTON</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA GLASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216282615</u>		17. INFORMANT <u>DAUGHTER</u> ADDRESS <u>MRS. CATHERINE CARUSO, 806 JAYDEE</u>	
18. <u>412.2 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CONGESTIVE HEART FAILURE</u>		<u>30 DAYS</u>	
ANTECEDENT CAUSES		(B) <u>MULTIPLE PULMONARY EMBOLI</u>		<u>30 DAYS</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		<u>10 YEARS</u>	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>CHRONIC PULMONARY OBSTRUCTIVE DISEASE UNKNOWN</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from <u>24 NOV.</u> 19 <u>71</u> to <u>7 JAN.</u> 19 <u>72</u> that (N) (we) last saw the deceased alive on <u>7 JAN.</u> 19 <u>72</u> and that (N) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William D. Hillis, M.D.</u>		23B. DATE SIGNED <u>7 JAN 72</u>		23C. PHYSICIAN'S NAME (Type) <u>WILLIAM D. HILLIS M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D. BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		25D. ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P. 362		72 00301		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00301	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mary R. Peterson</u>				2. DATE AND HOUR OF DEATH <u>Jan. 17/92 12:05 noon M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21222</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Balto General Hospital</u>						C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
						E. STREET AND NUMBER <u>3124 Shortway</u> <u>5300</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-92</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Zamenski</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Balcer</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>220-07-2793</u>		17. INFORMANT <u>Husband: Frank J. Peterson</u> ADDRESS <u>3124 Shortway Dundalk, Md. 21222</u>			
18. <u>562.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenie, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11</u> 19 <u>72</u> to <u>Jan. 7</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Geo. J. Noh</u> DEGREE				23B. DATE SIGNED <u>Jan 7/92</u>		23C. PHYSICIAN'S NAME (Type) <u>John E. Duda</u>			
				23D. ADDRESS <u>South Balto. Gen. Hospital Balto. Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Noh</u>		25C. FUNERAL DIRECTOR <u>John E. Duda</u>		ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>			





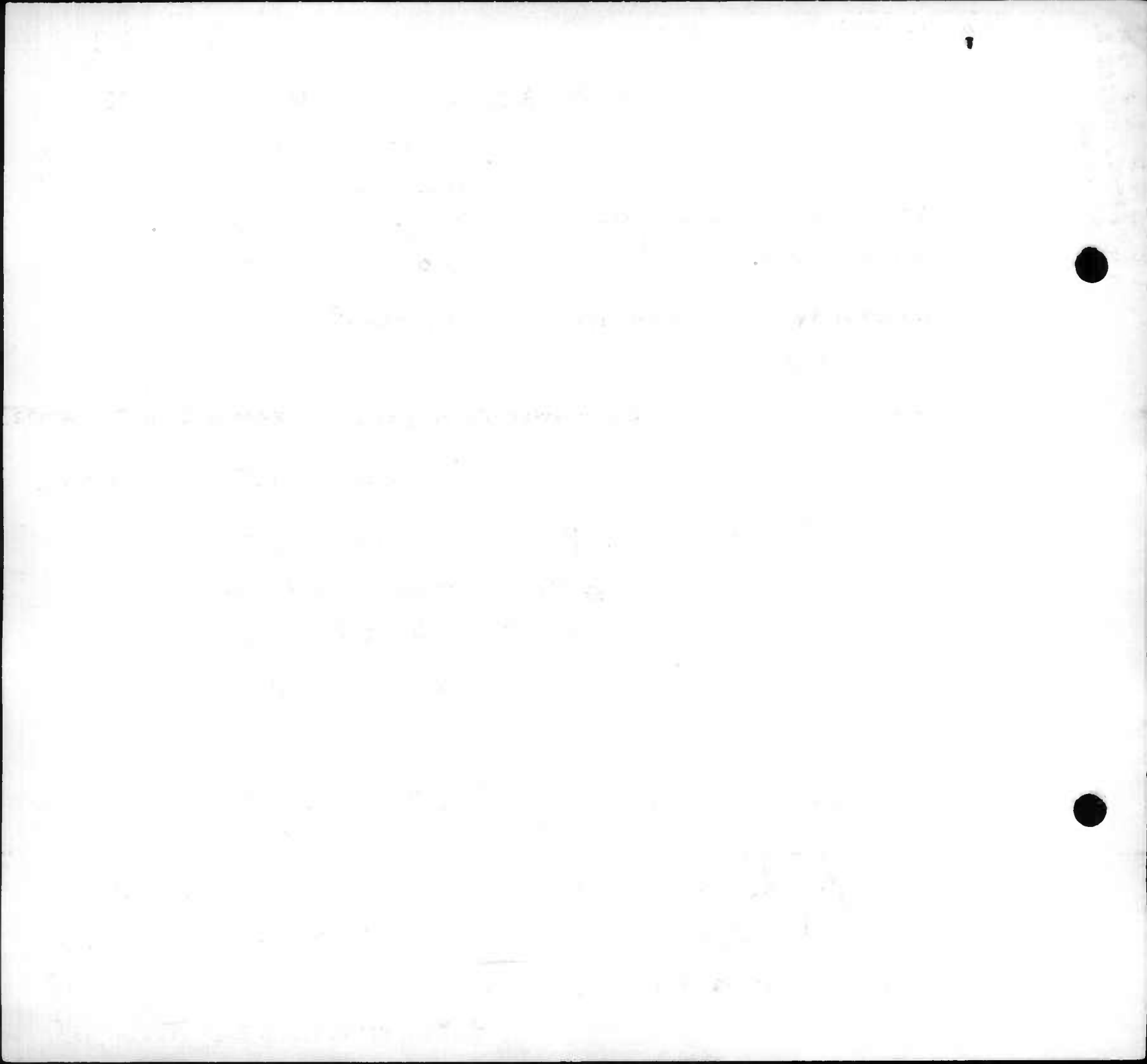
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-610		72 00302		BALTIMORE CITY HEALTH DEPARTMENT		72 00302	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>ESTELLE C. HARVEY</u>				2. DATE AND HOUR OF DEATH <u>1-8-72</u> <u>7:45pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2404</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 1512 BOYLE ST. BALTO. MD. 21230</u>				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1532 BOYLE ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-90</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACH. OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BAG FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BENJAMIN</u>				14. MOTHER'S MAIDEN NAME <u>CASKEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-8237</u>		17. INFORMANT <u>MRS. DORIS HAMPTON</u>		ADDRESS <u>1512 Boyle ST.</u>	
18. <u>412.41 + 153.3</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Hypertensive Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiovascular Disease &amp; Myocardial Infarction</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Coronary Artery Disease &amp; Atherosclerosis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular Disease &amp; Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery Disease &amp; Atherosclerosis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u> <u>1966</u> <u>5 yrs</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>72</u> to <u>1/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edw. J. Johnson M.D.</u>				23B. DATE SIGNED <u>1/10/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Edw. J. Johnson M.D.</u>				23D. ADDRESS <u>3432 Frederick RD. BALTO. MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-12-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>CEDAR HILL</u>		24D. LOCATION (City, town, or county) (State) <u>RITCHIE HWY. BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>John ...</u>		ADDRESS <u>4200 Pennington Ave.</u>	

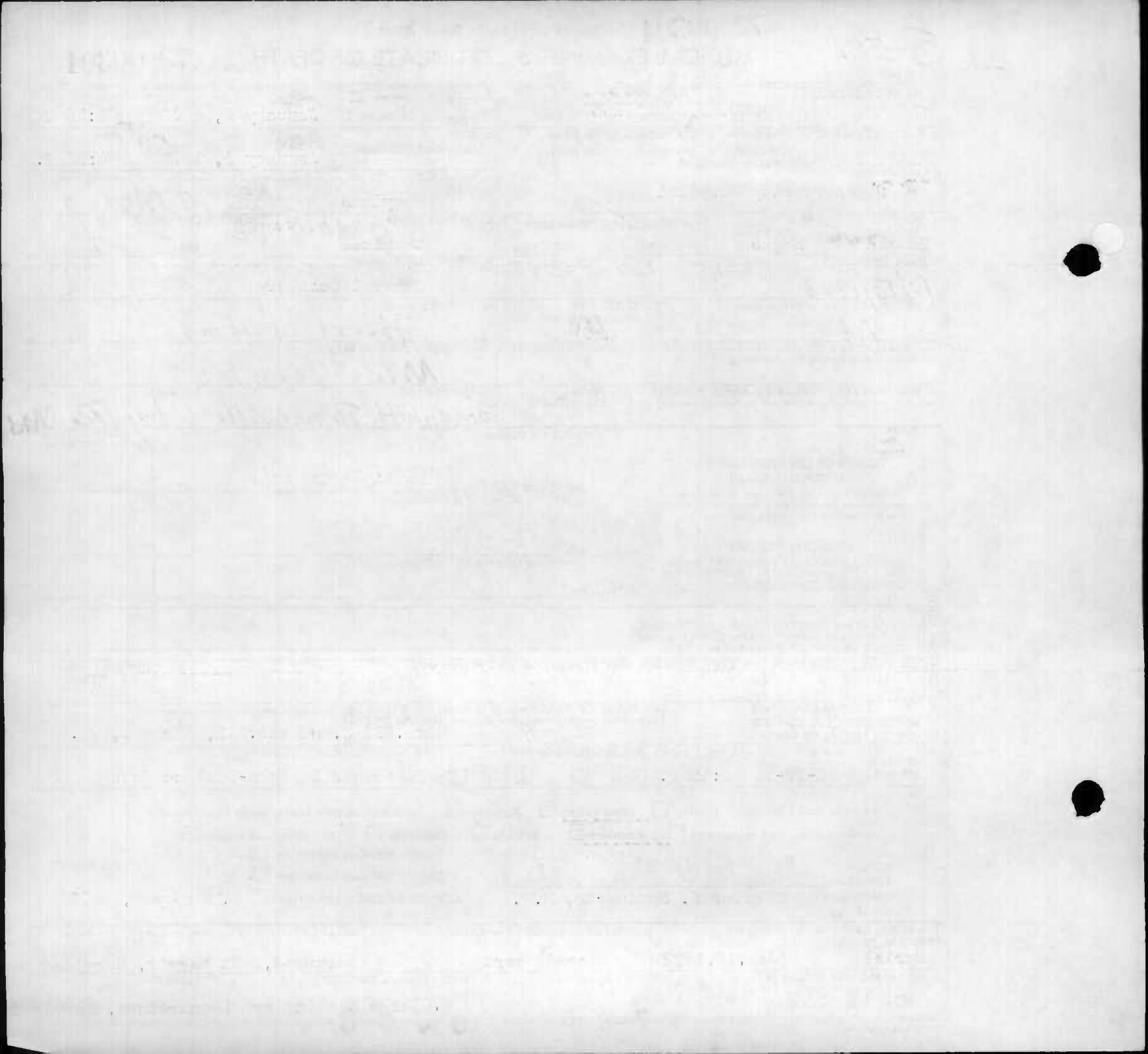


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		72 00303		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00303	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARTHA A. DAVIS</u>				2. DATE AND HOUR OF DEATH <u>1/10/72</u> <u>4<sup>00</sup></u> <u>PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>241 B. Rodgers Forge Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/98</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Herman Palm</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Lang</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>215-05-6046B</u>		17. INFORMANT <u>Wm. N. DAVIS</u>		ADDRESS <u>8400 ELLISON RD. 21093</u>		
18. <u>4/12-21</u> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Hypertensive atherosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular disease</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Congestive Heart failure</u>									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 9</u> 19 <u>72</u> to <u>Jan 10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan 10</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>W. Rohde MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/10/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>W. ROHDE</u>				23D. ADDRESS <u>601 N. Broadway, Balt. Md</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-13-72</u>		24C. NAME OF CEMETERY OR CREMATOR <u>DULANEY VALLEY MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>Timonium Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>John E. Valley MD</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc.</u>		ADDRESS <u>Towson Md.</u>			



VS 151-DEV 3/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-400		72 00305		BALTIMORE CITY HEALTH DEPARTMENT		X		72 00305	
BIRTH NO.		7-400		72 00305		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Foley, John Dennis</b>				2. DATE AND HOUR OF DEATH <b>1/3/72 11:50 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ST. MARYS</b> C. CITY OR TOWN <b>LEONARDTOWN</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>ROUTE 2</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MD HOSPITAL</b>				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38</b>					
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/25/53</b>		9. AGE (In years lost birthday) <b>18</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES W. FOLEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY R. CRYER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215 64 5909</b>		17. INFORMANT <b>Charles W. Foley</b> ADDRESS <b>Route 2 Leonardtown, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cardiac arrest</b> 1. <b>1/3/72</b> 2. <b>Cardiac arrest</b> 3. <b>Pulmonary insufficiency</b> 4. <b>Chest Trauma, Contused lung, Brain stem injury, hepatic</b> 5. <b>Paraplegia 2nd &amp; 3rd spine</b> 6. <b>Hepatic &amp; Renal Failure</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/3-72</b> <b>↑</b> <b>12/25-71</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>									
19A. DATE OF OPERATION <b>12/25-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hemorrhage</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <b>Highway</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Leonardtown, Md. 68-00</b>					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>12/25-71 5:00 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell off motorcycle</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> 19 <b>71</b> to <b>1/3</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/3 (11:50 PM)</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jeremy M. Ramp MD</b>				23B. DATE SIGNED <b>1/4-72 (12:20 AM)</b>					
23C. PHYSICIAN'S NAME (Type) <b>Jeremy M. Ramp MD</b>				23D. ADDRESS <b>University of Maryland Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 7, 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Francis Xavier</b>		24D. LOCATION (City, town, or county) (State) <b>Compton, St Mary's, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b>		25C. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Maryland</b>			





H-236

72 00306

BALTIMORE CITY HEALTH DEPARTMENT

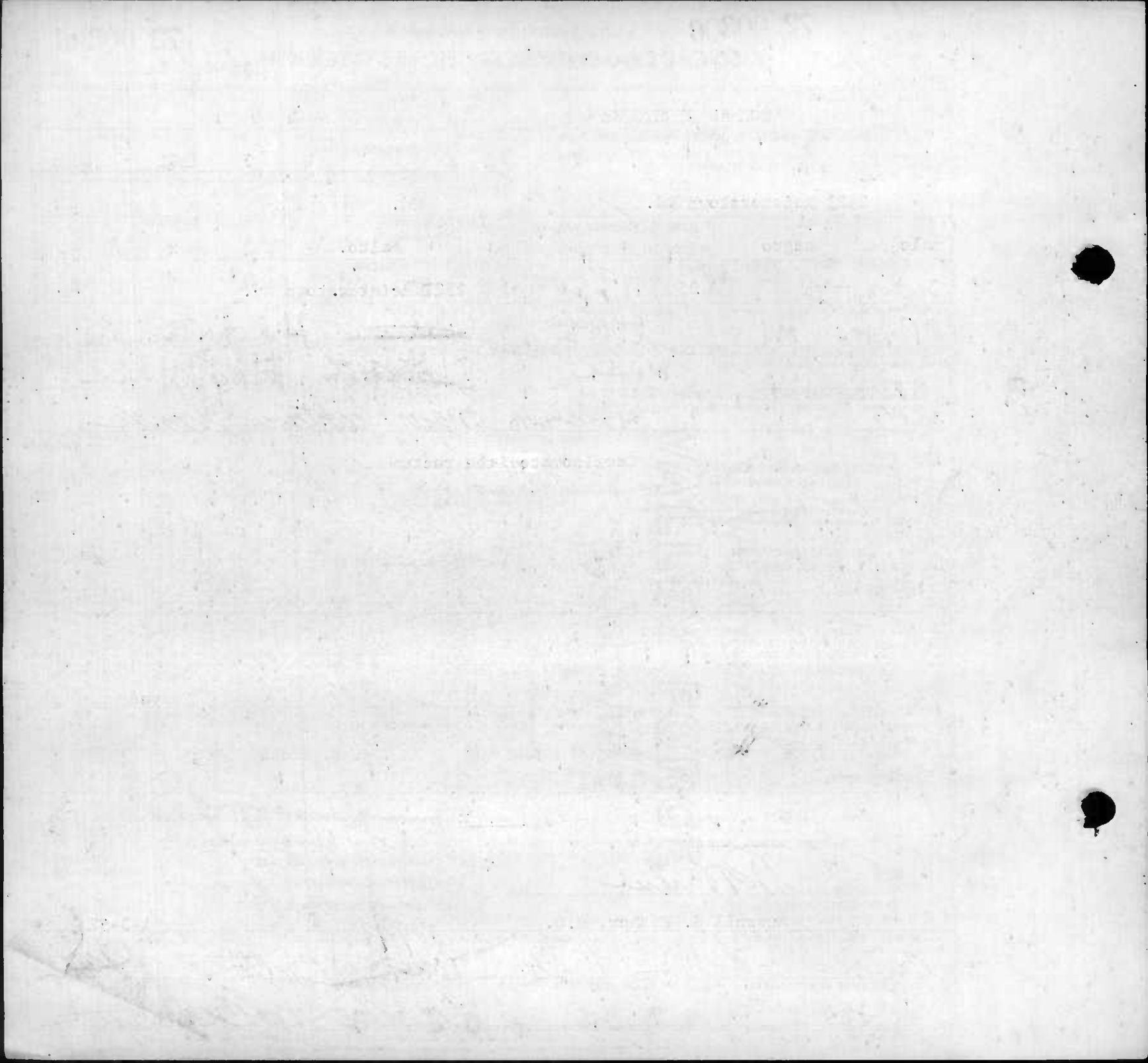
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00306

BIRTH NO.

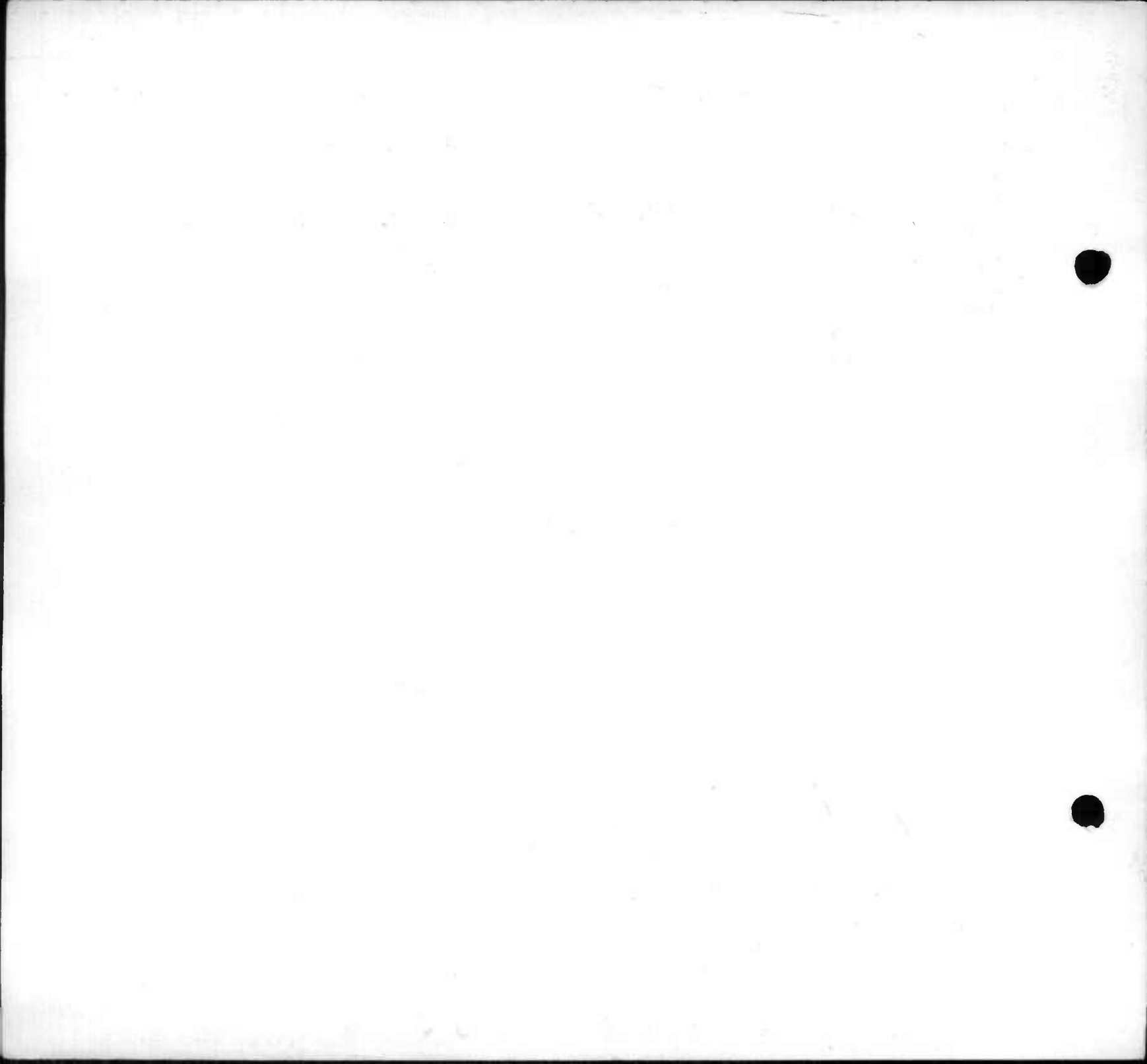
REG. NO.

1. NAME OF DECEASED (Type or Print) <b>NORMAN HIGHTOWER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2525 Reisterstown Rd.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 3 1972 2:40 a.m.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Sept 2, 1938</b>		10. AGE (In years last birthday) <b>35</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-72-4270</b>	
18. INFORMANT <b>May Hightower</b>		ADDRESS <b>1304</b>	
19. <b>154.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the rectum</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-3-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-8-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Anne's</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Russell S. Fisher</b>	
25C. FUNERAL DIRECTOR <b>1077 Brambleton</b>		ADDRESS <b>Baltimore</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

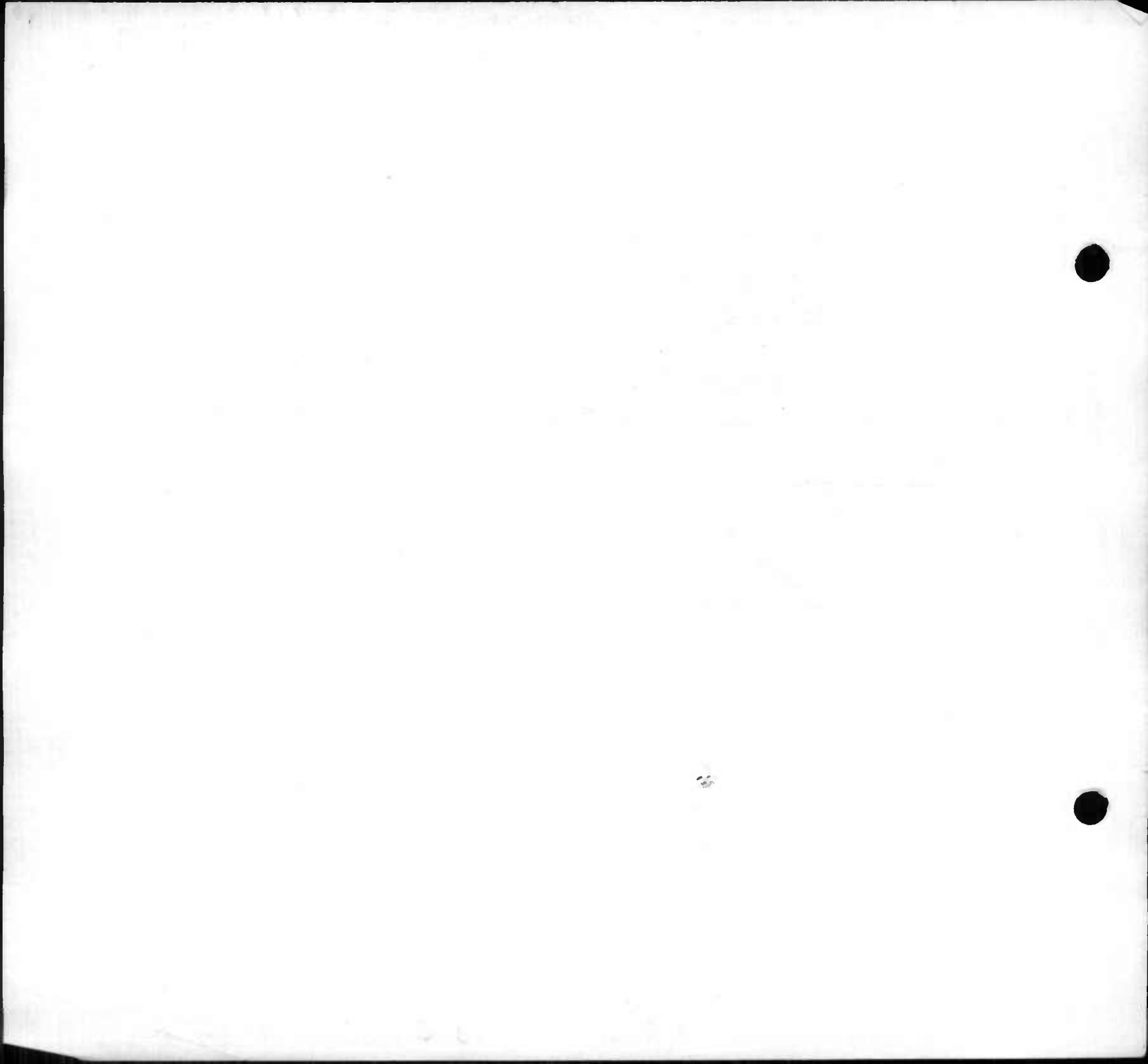
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00307</u>	
BIRTH NO. <u>D-525</u>		72 00307			
1. NAME OF DECEASED (Type or Print) <u>DUNSON, Rossie</u>			2. DATE AND HOUR OF DEATH <u>1/10/72</u> <u>7:10 a.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>			A. STATE <u>B</u> Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>1302 N. Chester Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/29</u>	9. AGE (In years last birthday) <u>42</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Debham</u>			14. MOTHER'S MAIDEN NAME <u>Jessie Davis</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Carl Debham Same</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>428X</u> CAUSE OF DEATH <u>CARDIO-RESPIRATORY ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 HRS</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>1/9</u> 19 <u>72</u> to <u>1/10</u> 19 <u>72</u> that (1) (we) lost saw the deceased alive on <u>1/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>YOSHIZUMI, MD</u>				23B. DATE SIGNED <u>1/10/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>YOSHIZUMI, M.D.</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-14-72</u>		24C. NAME of CEMETERY or CREMATORY <u>mt Arden Cat</u>	
24D. LOCATION <u>Balto</u>		24E. (City, town, or county)		24F. (State) <u>md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>8000 Prunty St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00308</u>	
<p>W-231 72 00308</p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>WAGSTAFF IVERN</u></p>		<p>2. DATE AND HOUR OF DEATH <u>1-6-72</u> <u>340</u> <u>P</u> M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV of Md. Hosp.</u> <u>38</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1001</u></p> <p>C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>UNK 936 E. Dickell St</u></p>			
<p>5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>12-1-25</u> 9. AGE (In years last birthday) <u>46</u></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNK Steel Worker</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>UNK</u></p>			
<p>11. BIRTHPLACE (State or foreign country) <u>UNK North Carolina</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>			
<p>13. FATHER'S NAME <u>UNK John A. Wagstaff</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Ruth Brooks</u></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u> <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>343-32-0223</u></p>		<p>17. INFORMANT <u>Robert A. Wagstaff</u> ADDRESS <u>2783 Sivaly Ave #21218</u></p>	
<p>18. <u>569.9 I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: <u>IMMED</u></p> <p>(B) <u>HYPOTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>10 hours</u></p> <p>(C) <u>BOWEL EDEMA &amp; ILEUS</u> <u>10 hours</u></p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>SHOCK</u> <u>LIVER disease, Non ketotic hyperosmotic coma</u> <u>chronic</u></p>					
<p>19A. DATE OF OPERATION <u>2</u> NONE</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>1-6-72</u> 19 to <u>1-6-72</u> 19 that (I) (we) last saw the deceased alive on <u>1-6-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Robert A. Lessey MD</u></p>		<p>23B. DATE SIGNED <u>1-6-72</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>ROBERT A. LESSEY</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>1-11-72</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>North Zion Cont</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>North Carolina</u></p>		<p>25A. RECORD BY HEALTH DEPT. <u>JAN 12 1972</u> 25B. NAME OF REGISTRAR <u>Robert A. Lessey, M.D.</u> 25C. FUNERAL DIRECTOR <u>Robert A. Lessey</u> ADDRESS <u>2783 Sivaly Ave #21218</u></p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00309	
G-355 72 00309					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) GOODMAN, NELLIE			2. DATE AND HOUR OF DEATH JAN 8 1972 3:20 PM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY BALTIMORE		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2101 E Chase St		
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/12	9. AGE (In years lost birthday) 59	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) ?		
10B. KIND OF BUSINESS OR INDUSTRY —			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown Herbert Ward		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. ?		
			17. INFORMANT UNKNOWN		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.317-250.9			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST</p> <p>(B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: ? ARTERIO-SCLEROTIC HEART DISEASE</p> <p>(C) ?</p>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			DIABETES MELLITUS / PULM EDEMA / PNEUMONIA		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6 AM 19 72 to 8 AM 19 72 that (I) (we) last saw the deceased alive on 8 AM 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Schultze MD				23B. DATE SIGNED 8 JAN 19 72	
23C. PHYSICIAN'S NAME (Type) DR. THOMAS SCHULTZ M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-13-72		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cal	
24D. LOCATION Baltimore		24E. CITY, TOWN, OR COUNTY Baltimore		24F. STATE MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR D. J. Schultze		25C. FUNERAL DIRECTOR D. J. Schultze	
				ADDRESS 1001 Chantilly Ln	

11 JUL 1964  
COMMUNIST PARTY  
T.C.

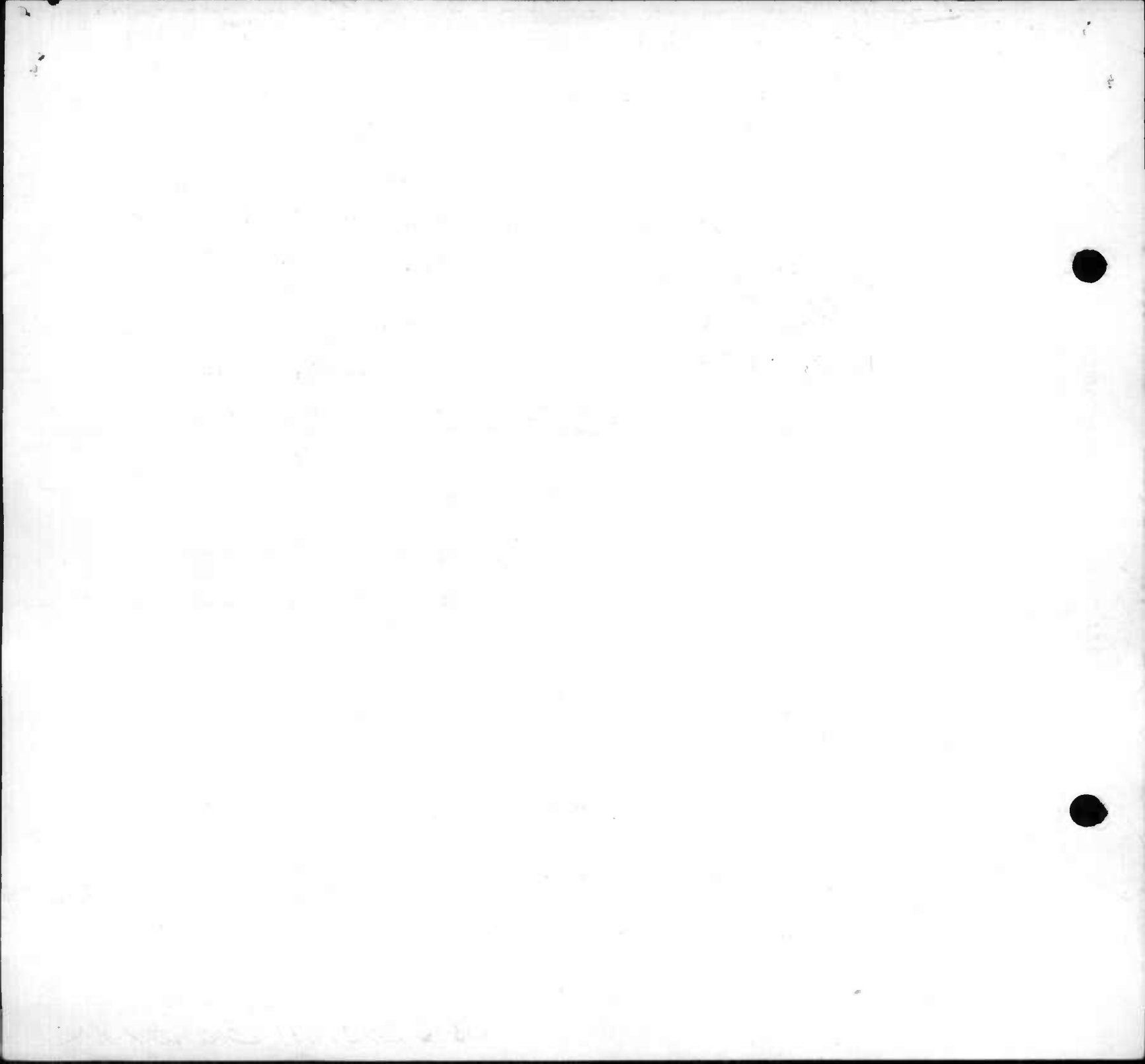
RECEIVED  
11 JUL 1964



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

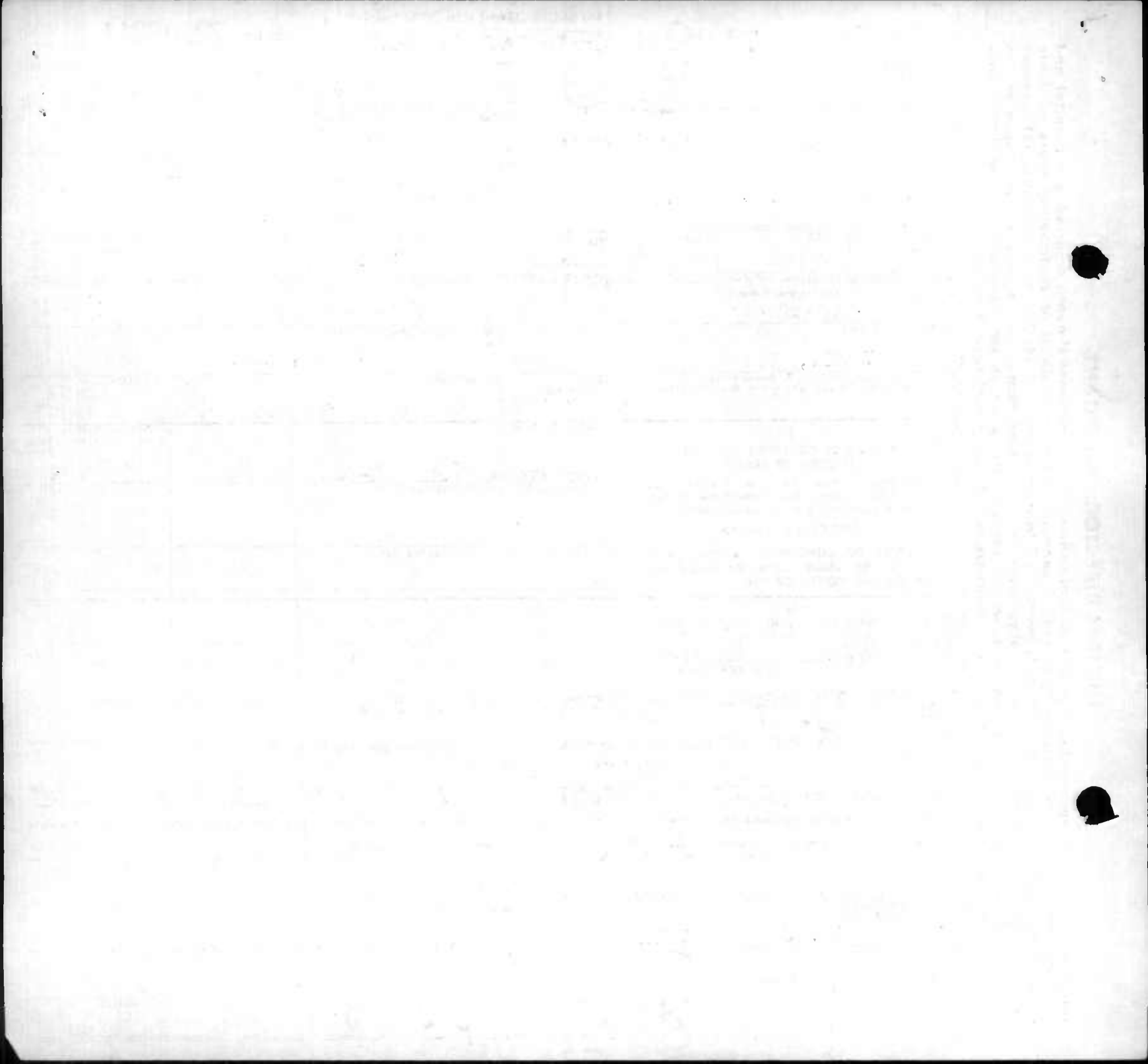
M-460 72 00310		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00310	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MILLER, Theodore</i>		2. DATE AND HOUR OF DEATH <i>1-7-72 1200</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		M. <i>501</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>07/25/30</i>		9. AGE (In years last birthday) <i>41</i>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>MILLER, MILTON</i>		14. MOTHER'S MAIDEN NAME <i>WILSON, ELSIE</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215 22 7601</i>		17. INFORMANT <i>Debra Miller Arme</i>	
18. <i>1621 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Cardiovascular Collap</i> <i>Carcinoma of lung</i> <i>Carcinoma of lungs</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 months</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>9-21-1971</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intractable pain</i>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1/7</i> 19 <i>72</i> to <i>1/7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1:45 pm</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <i>Sumio Uematsu M.D.</i>		23B. DATE SIGNED <i>1/7-72</i>		23C. PHYSICIAN'S NAME (Type) <i>Sumio UEMATSU</i>	
23D. ADDRESS <i>601 North Broadway, Balt.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>1-13-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cmt</i>		24D. LOCATION (City, town, or county) (State) <i>All County</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 12 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>1813 Broad 1000 Brantly Jr</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00311	
B-650 72 00311 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>BROWN LUCY</b>		2. DATE AND HOUR OF DEATH <b>7 January 1972 8 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>918 HARLEM AVE</b>			
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1895</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>STOKES, SERR</b>		14. MOTHER'S MAIDEN NAME <b>STOKES, ELLEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>W</b>		16. SOCIAL SECURITY NO. <b>216 03 0486</b>		17. INFORMANT <b>Common Brown Serr</b>	
18. <b>4 36.01</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Vascular Accident</b>		<b>1 1/2 wks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <b>Hypertension</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypertension</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1-2-72</b> 19 <b>71</b> to <b>1-7</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>1-7</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James F. Martin</b>				23B. DATE SIGNED <b>1-7-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. JAMES MARTIN</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>White Mt</b>	
24D. LOCATION (City, town, or county) (State) <b>White Mt</b>		24E. FUNERAL DIRECTOR <b>Wm. J. Brown</b>		24F. ADDRESS <b>1007 Broadway St</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>John F. Kelly</b>		25C. NAME OF REGISTRAR <b>John F. Kelly</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT WHITE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 8, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1239 Ashland Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 8, 1972 4:45 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Jan 23-1916</b>		10. AGE (in years lost birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Crew Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Louise Single 7204 North Rd</b>		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE <b>Fatty metamorphosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>1-14-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Not Cahay Cat</b>		24D. LOCATION (City, town, or county) (State) <b>Adm County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Reed J. ...</b>	
25C. FUNERAL DIRECTOR <b>...</b>		ADDRESS <b>...</b>	

2-10-1972 - Letter from - Office of the Chief Medical Examiner, C. Springate, M.D.

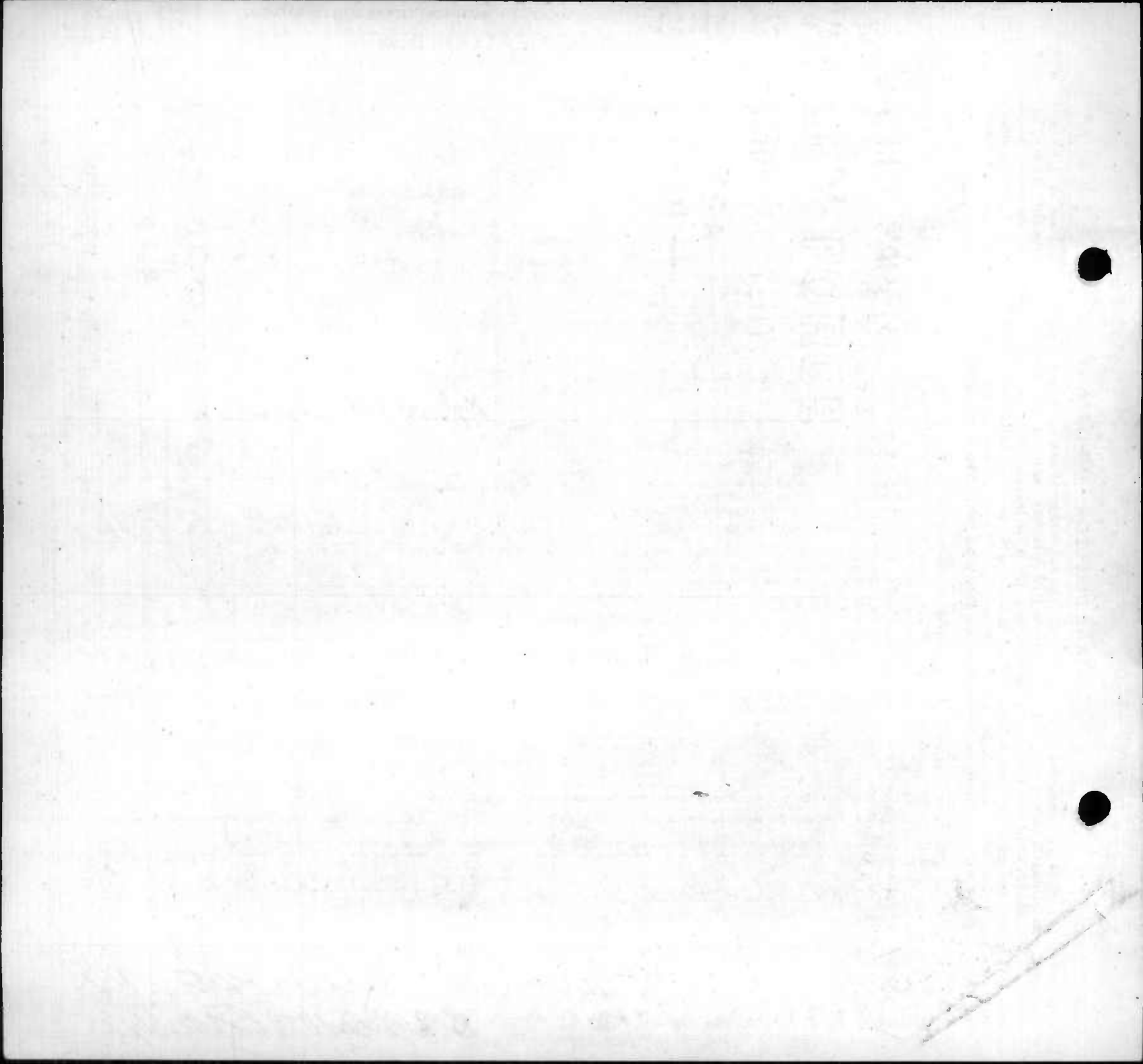
HRS



# FUNERAL DIRECTOR: IMPORTANT

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B-560 72 00313				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00313	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Baynor, Ada McClure</i>				2. DATE AND HOUR OF DEATH <i>5:30 PM 1/6/72 M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>45 Good Samaritan Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Good Samaritan Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>323 E. Lamar Avenue Street</i>							
5. SEX <i>F</i>	6. RACE <i>B</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-30-21</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>McCurse, Benny</i>				14. MOTHER'S MAIDEN NAME <i>Edna (last name unknown)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-18-821</i>		17. INFORMANT ADDRESS <i>Edna McClure</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>0</i> 20A. AUTOPSY? (Yes or No) <i>0</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>0</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 hours</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>1/6</i>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/26/71</i> 19 <i>71</i> to <i>1/6</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>1/6</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stephen B. Baylin M.D.</i>				23B. DATE SIGNED <i>1/6/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Stephen B. Baylin M.D.</i>	
23D. ADDRESS <i>323 E. Lamar Avenue</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-11-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Carey Cmt.</i>		24D. LOCATION (City, town, or county) (State) <i>AA County Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 12 1972</i>		25B. NAME OF REGISTRAR <i>2200 1000</i>		25C. FUNERAL DIRECTOR <i>2200 1000</i>		ADDRESS <i>2200 1000</i>	

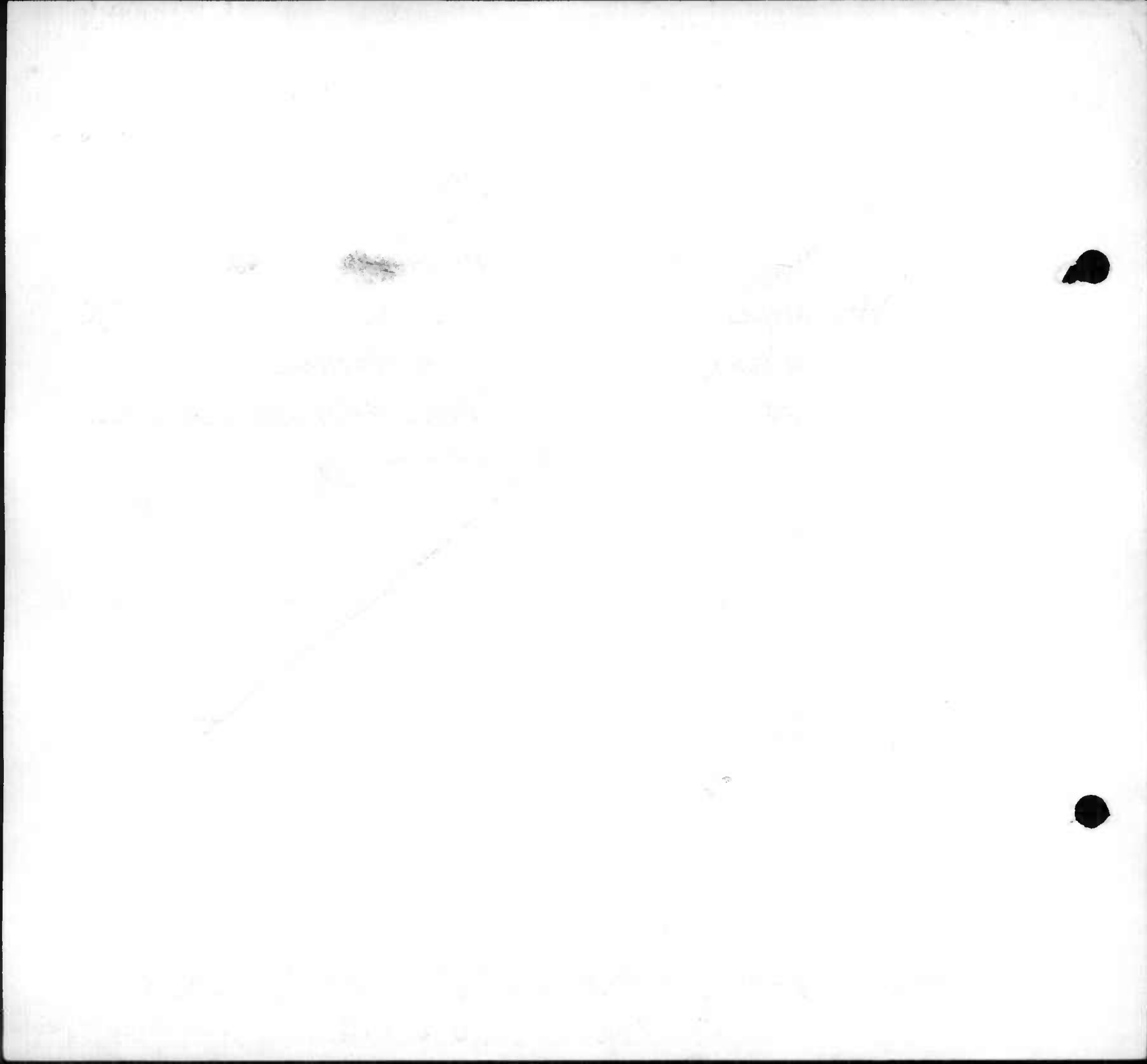




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <span style="font-size: 1.5em;">B-520</span> <span style="font-size: 1.5em;">72 00314</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BANKS AMELIA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1/5/72 at 4:30 P. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">2037</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">46 Lutheran</span>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.2em;">Balto, Md</span>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">3429-Edmondson, ave</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">C</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11-24-09</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">62</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">S.C</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">unknown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unknown</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Alicia F Banks Same</span>	
18. <span style="font-size: 1.2em;">792X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Leukemia</span>		CAUSE OF DEATH <span style="font-size: 1.2em;">Leukemia</span>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/21</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">1/5</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/5</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Anjana Joshi</span>		M.D. DEGREE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		<span style="font-size: 1.2em;">ANJANA JOSHI M.D.</span>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">1-10-72</span>		<span style="font-size: 1.2em;">Mt Antoinette</span>	
24D. LOCATION (City, town, or county) (State)		<span style="font-size: 1.2em;">Balto Md</span>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.2em;">JAN 12 1972</span>		<span style="font-size: 1.2em;">Robert E. Jones</span>		<span style="font-size: 1.2em;">1000 BRANTLEY AVE</span>	



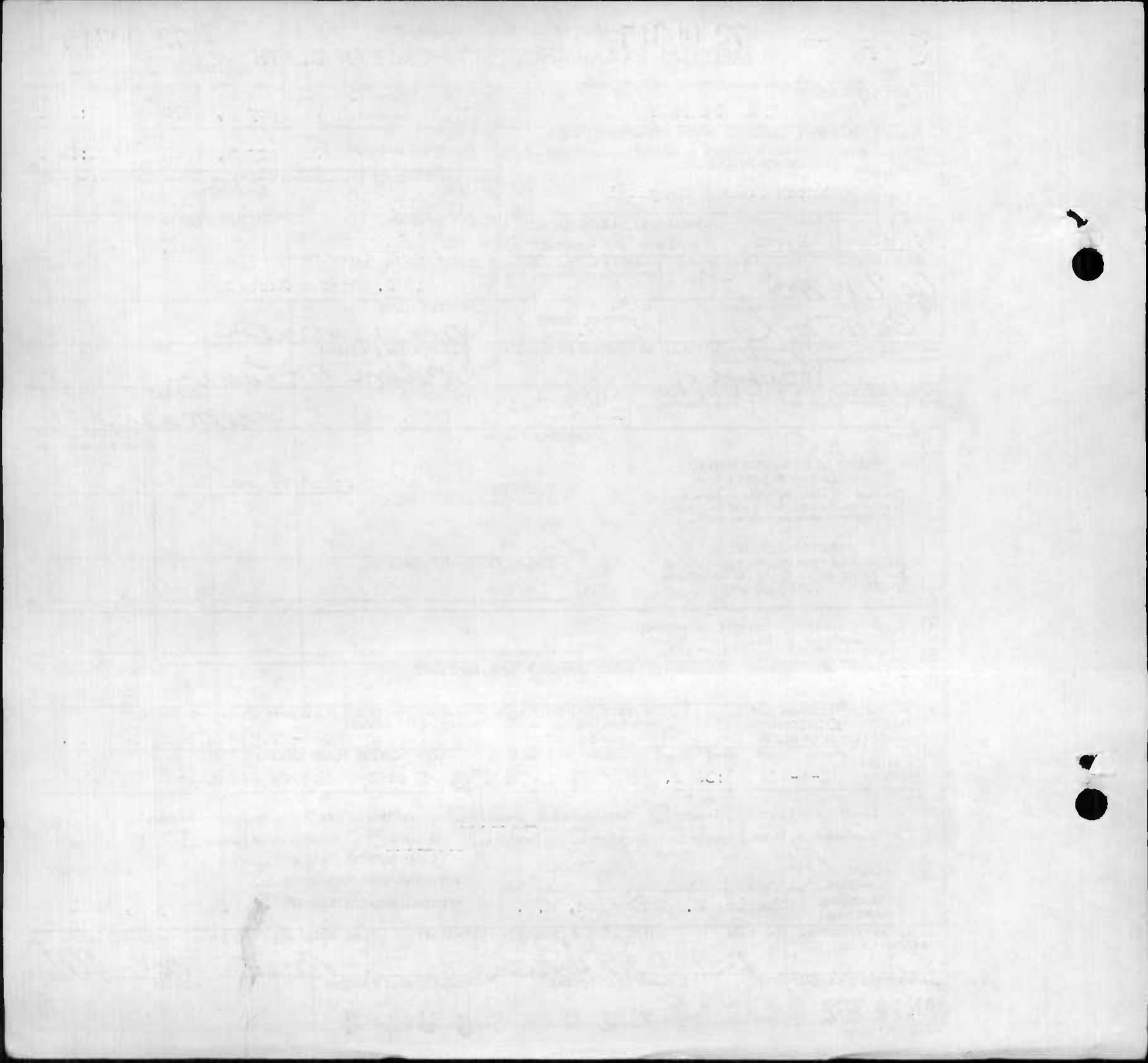
S-315

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>IDA STEPNEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>January 5, 1972 12:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 5, 1972 12:30 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>April 12 1943</b>		10. AGE (In years fast birthday) <b>28</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>214-389003</b>	
18. INFORMANT <b>Doretha Gaslin</b>		ADDRESS <b>1715 Madison Ave.</b>	
19. CAUSE OF DEATH <b>E9651X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Tavern</b>	
22D. TIME OF INJURY (APPROX.) <b>1-4-72 7:30 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>"Daves Bar" - Fayette &amp; Exeter Sts.</b>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Not known</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Blair E. ...</b>	
25C. FUNERAL DIRECTOR <b>Choy Wilson</b>		ADDRESS <b>1000 Broomfield Ave</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roland L. Wickham		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 1	Day 7	Year 72	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD		Month 1	Day 7	Year 72	Hour 1:30 a.m.
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO 5300	
9. DATE OF BIRTH Jun 29, 1925		10. AGE (In years last birthday) 46		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alvin Bear		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Blanch M. Wickham		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. Unknown		18. INFORMANT Harbough Valley Rd. Melvin E. Smith, Sabillasville, Md.		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO	
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22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE: Peter Lipkovic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
DATE SIGNED 1/7/72					

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 11, 1972		24C. NAME of CEMETERY or CREMATORY Mount Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frederick, Frederick, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR M. R. Etchison & Son		ADDRESS 100 East Church Street Frederick, Md.	

Approved for release by NSA on 08-28-2014 pursuant to E.O. 13526

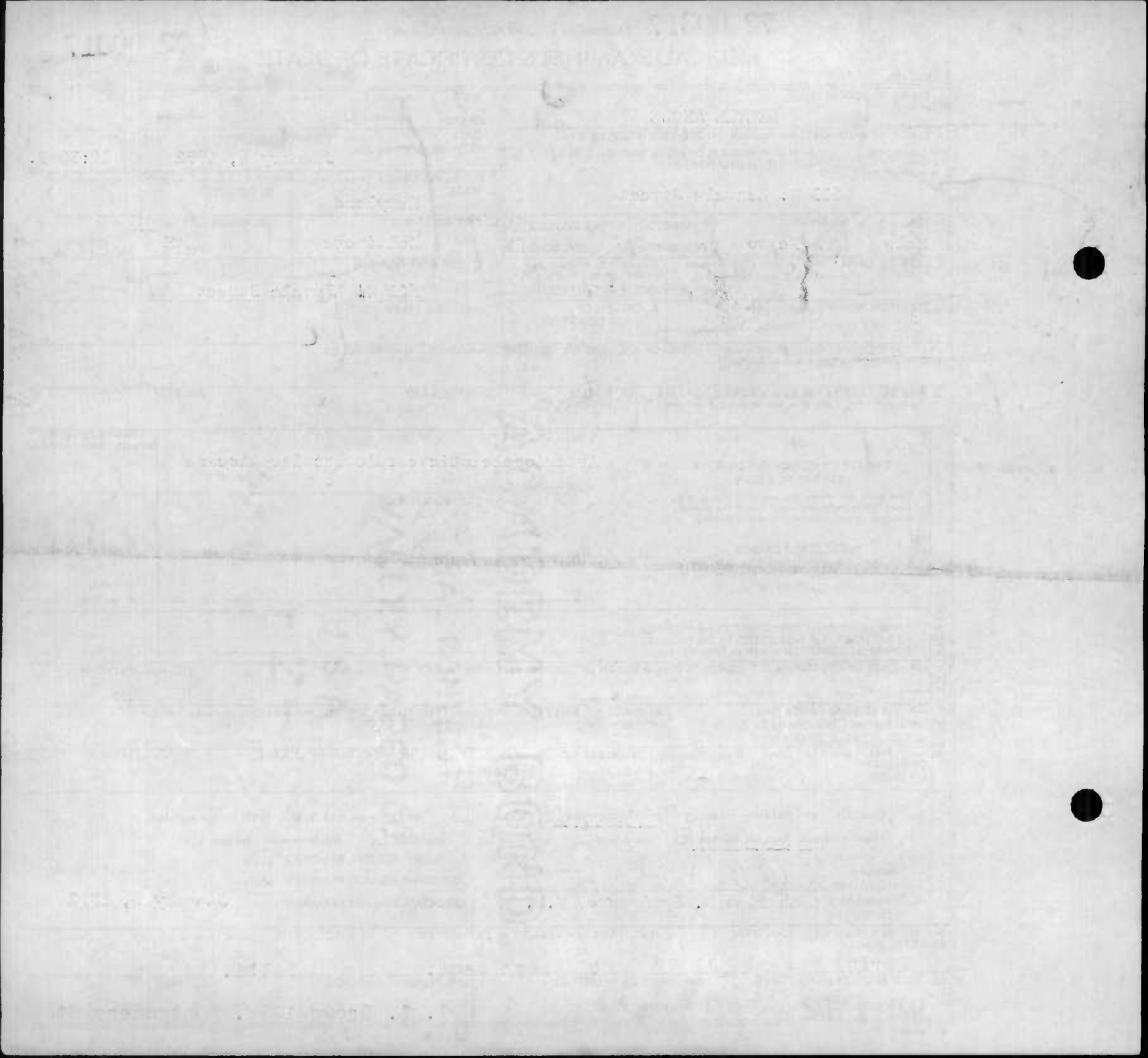
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>MELVIN ANGLE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>523 W. Lanvale Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 6, 1972</b> Hour <b>12:30 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>70</b>		10. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1702</b>	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 6, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-11-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cent.</b>		24D. LOCATION (City, town, or county) (State) <b>Balti. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>I. L. Brown</b>		25D. ADDRESS <b>123 W. Montgomery St.</b>	







This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B

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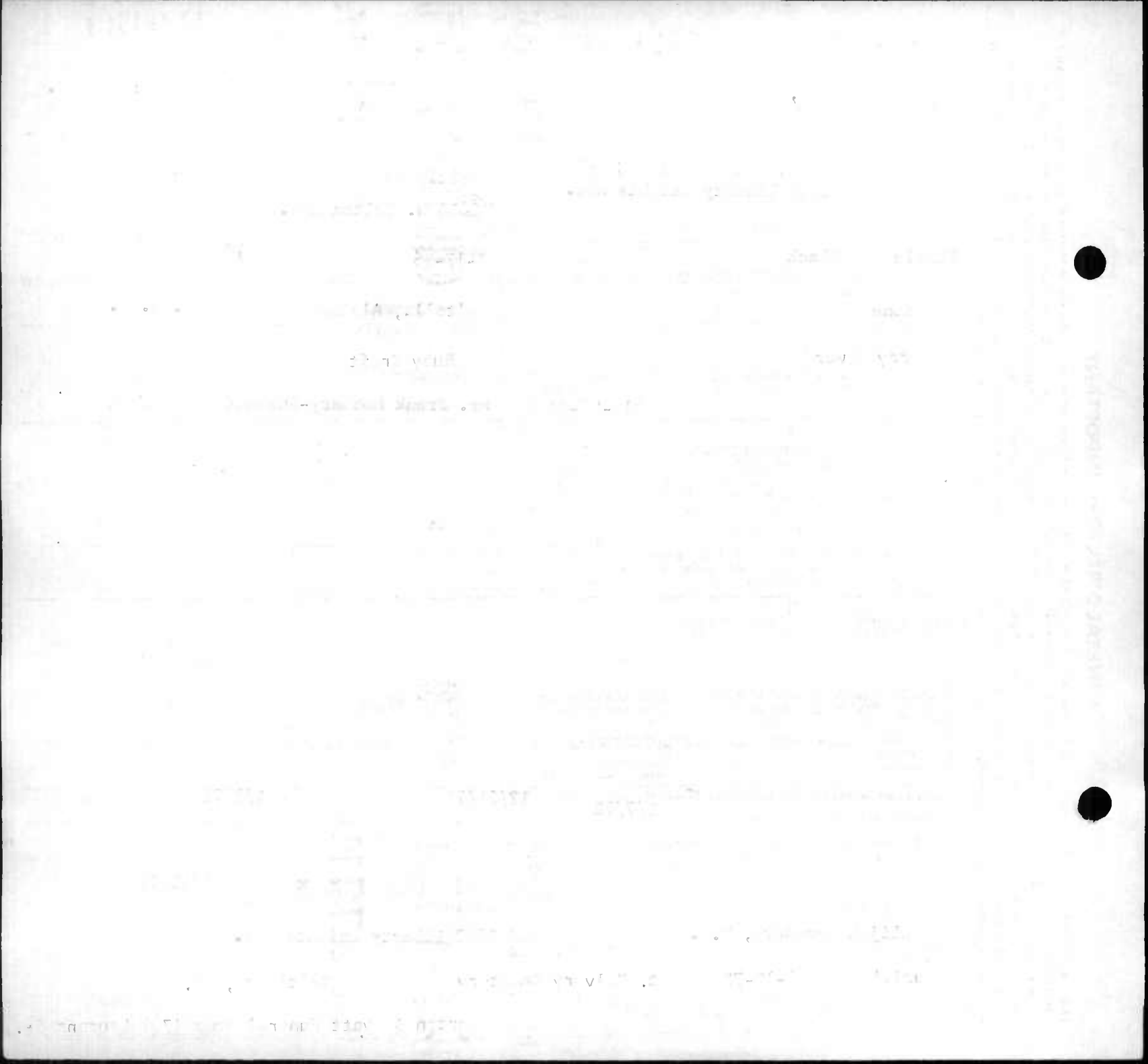
Section (Hill) - 100 ft

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00319	
M-160 72 00319				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Mobuary, Rosie</u>			2. DATE AND HOUR OF DEATH <u>1/7/72</u> <u>9:00</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital Complex</u> <u>2600 Liberty Heights Ave.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1504</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2014 N. Fulton Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-26</u>		9. AGE (in years last birthday) <u>45</u> 11. Under 1 Yr. Months Days 12. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Altalla, Alabama</u>	
13. FATHER'S NAME <u>Derry Howard</u>			14. MOTHER'S MAIDEN NAME <u>Ruby Craft</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>419-26-9008</u>		17. INFORMANT <u>Mr. Frank Mobuary-Husband</u> ADDRESS <u>Same</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CUA 2° to cerebral Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HCV</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HCV</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>? years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NONE</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/31/71</u> 19 to <u>1/7/72</u> 19 that (I) (we) last saw the deceased alive on <u>1/7/72</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Saunders</u> DEGREE				23B. DATE SIGNED <u>1/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Elijah Saunders, M.D.</u>				23D. ADDRESS <u>2600 Liberty Heights Ave.</u> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-12-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>John J. ...</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett Funeral Home</u> ADDRESS <u>1701 Laurens St.</u>	



T-520

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00320

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Paul Thomas				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 11 72 12:45 A.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 11 72 12:45 A.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-28-49				10. AGE (in years last birthday) 22		11. BIRTHPLACE (State or foreign country) Clarkton, N. C.	
12. CITIZEN OF U. S. A.				13. FATHER'S NAME Claude P. Thomas			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				15. MOTHER'S MAIDEN NAME Mable McKeithan			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.		18. INFORMANT Mabel Thomas	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1416 N. Mount Street				22D. TIME OF INJURY (APPROX.) Month Day Year Hour 1 9 72 ?			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? supposedly jumped from 2nd floor window			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Warner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Warner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-15-72			
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972				25B. NAME OF REGISTRAR Robert E. Johnson			
25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home				ADDRESS 1701 Laurens St.			

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72 00321

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00321

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GRACE ROBINSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 211 N. Culver St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 10 1972 10:20 a</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2037</b>		C. CITY OR TOWN <b>Balto.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>2-27-1920</b>		10. AGE (In years last birthday) <b>51</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles White</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Grace White</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Grace White 2836 Clifton Avenue</b>	
19. <b>571.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-10-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home 1701 Laurens St.</b>		ADDRESS	

2-3-1972 - Form -Completion of cause of death on a pending medical examiner death certificate

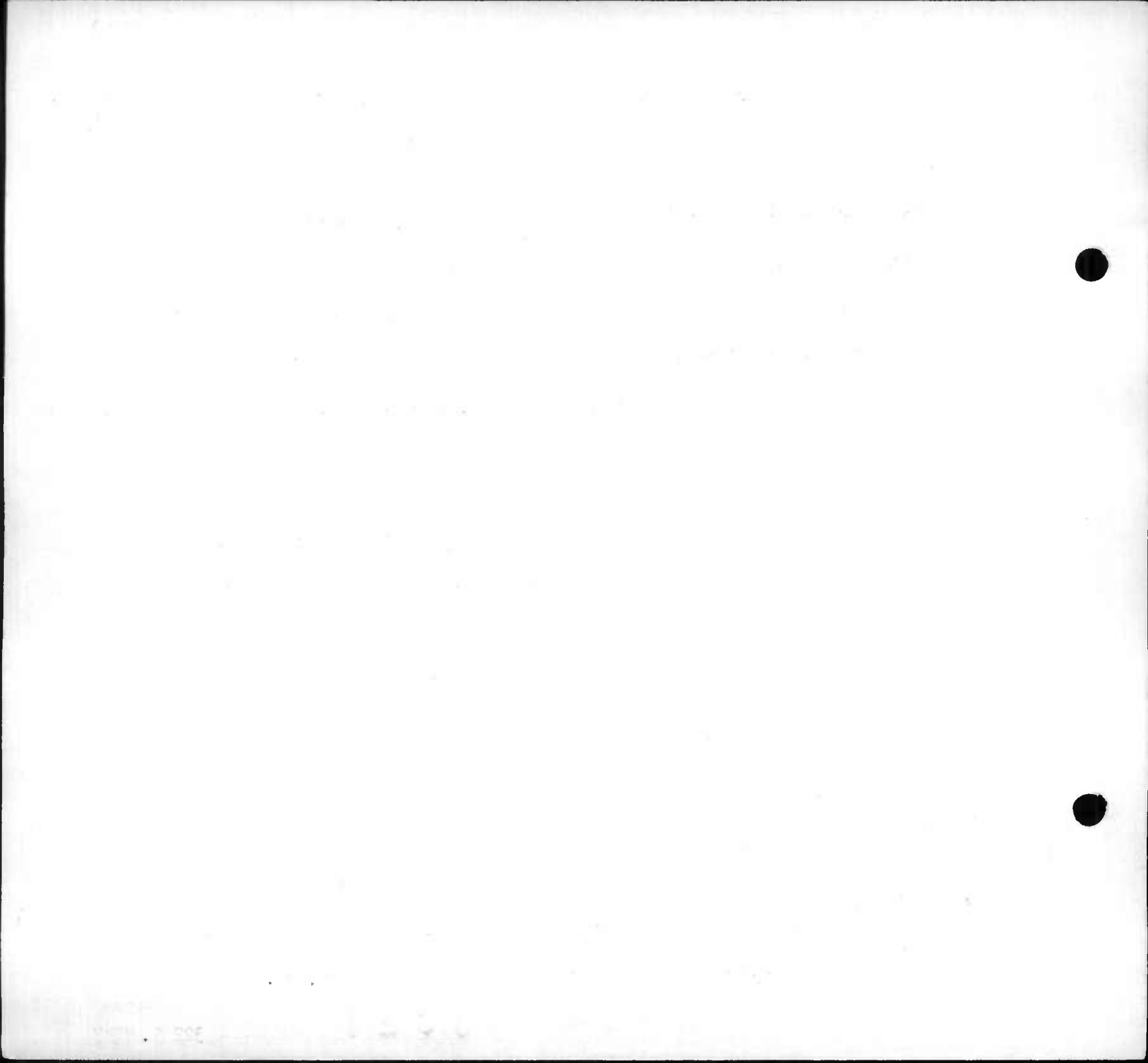
Russell S. Fisher, M.D.

HRS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 00322	
BIRTH NO. 72 00322		1. NAME OF DECEASED (Type or Print) Michael J. DeLorenzo		2. DATE AND HOUR OF DEATH 1/7/72 11:20 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 302 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 322 S. Albemarle Street		
5. SEX Male	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/59	9. AGE (In years last birthday) 12	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME Michael P. DeLorenzo			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. Michael P. DeLorenzo 322 S. High St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?  22. I certify that (this hospital) attended the deceased from 1/1 19 72 to 1/7 19 72 that (we) last saw the deceased alive on 1/7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.  23A. SIGNATURE Dianne S. Elfenbein, MD DEGREE 23B. DATE SIGNED Jan 10, 1972 23C. PHYSICIAN'S NAME (Type) Dianne S. Elfenbein, MD DEGREE 23D. ADDRESS The Johns Hopkins Hospital  24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 1/10/72 24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER 24D. LOCATION (City, town, or county) (State) BALTO. Md.  25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972 25B. NAME OF REGISTRAR Robert E. Fahey, MD 25C. FUNERAL DIRECTOR 25D. ADDRESS 322 S. HIGH					



## CERTIFICATE OF DEATH

REG. NO.

72 00323

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Joseph Cirillo

2. DATE AND HOUR OF DEATH

1-10-72

1230

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1124 Broening Highway

21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-27-17

9. AGE (In years last birthday)

54

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LOBORER

10B. KIND OF BUSINESS OR INDUSTRY

SANITATION DEPT.

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unitario

14. MOTHER'S MAIDEN NAME

Rose

MELI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

219-01-5634

17. INFORMANT

4940 Eastern Avenue  
BCH: Records Baltimore, Maryland 21224

18.

562.11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

SEPSIS

DUE TO, OR AS A CONSEQUENCE OF:

(B)

POST-OPERATIVE INFECTION

DUE TO, OR AS A CONSEQUENCE OF:

(C)

PARTIAL COAGULOPATHY FOR BLEEDING

DISEASES

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

24 hrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

PREVIOUS RESP-CARDIAC ARREST

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-15 19 71 to 1-10 19 72 that (I) (we) last saw the deceased alive on 1-10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. B. Leadbetter, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1-10-72

23C. PHYSICIAN'S NAME (Type)

W. B. Leadbetter, M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/13/72

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER

24D. LOCATION (City, town, or county)

BALTO. Md.

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 12 1972

25B. NAME OF REGISTRAR

W. E. Taylor, M.D.

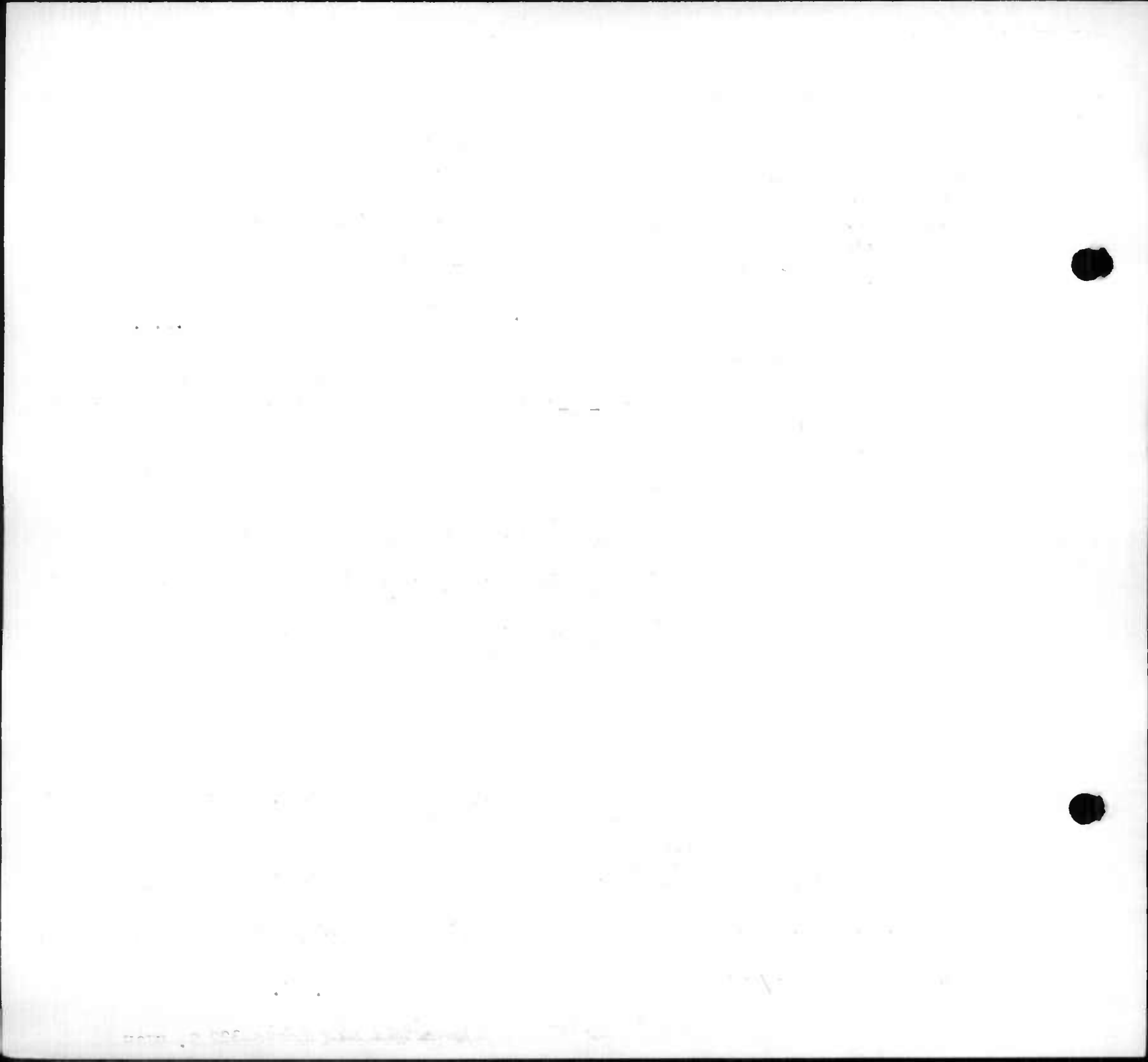
25C. FUNERAL DIRECTOR

322 S. HIGH

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00324	
72 00324				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LESTER TOMLYN DEVER.		January 10, 1972, 5:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00			A. STATE Md.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 910 S. Baylis St. Balto., 21224, Md.			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 910 S. Baylis St. #21224.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 19, 1905	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) York, Nebraska	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? Dever		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 111-07-5891		17. INFORMANT Van D. Dever	
18. 4 10 9 I		CAUSE OF DEATH		ADDRESS 8027 Dalesford Rd. Balto., 21234, Md.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION ASLUD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Obstructive pul. emphysema					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8-5-66 19 to 11-5 19 71 and that (1) (we) last saw the deceased alive on 10-2 11-5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aidan E. Walsh				23B. DATE SIGNED 1-12-72	
23C. PHYSICIAN'S NAME (Type) AIDAN E. WALSH				23D. ADDRESS 222 St. Paul St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-13-72		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles J. Giller		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.			



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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00325

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Anna Mae Beverly		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 4300 Liberty Heights Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 9 1972 1:45 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2802	
6. SEX female	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-7-1904		10. AGE (In years last birthday) 67	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Scott		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Annie Scott	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-09-2983		18. INFORMANT ADDRESS Mr. William H. Beverly 4300 Liberty Ht	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Incised wounds of left wrist		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4300 Liberty Heights 2802	
22D. TIME OF INJURY (APPROX.) 1-9-72		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject cut wrist with knife.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-10-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-13-1972		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE	



UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE ATTORNEY GENERAL

RE: [Illegible]

Page 1

TO: THE ATTORNEY GENERAL

FROM: [Illegible]

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

[Illegible Signature]

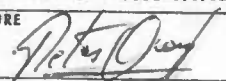
6. [Illegible]

7. [Illegible]

8. [Illegible]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00326</u>
BIRTH NO. <u>72 00326</u>				
1. NAME OF DECEASED (Type or Print) <b>ROBERT JONES</b>		2. DATE AND HOUR OF DEATH <b>1-9-72 8:05 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital &amp; Balto.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1511</b>		
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>3707 DENNLIN RD. #15</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-18-1891</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chef</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>? ?</b>		14. MOTHER'S MAIDEN NAME <b>? ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-14-9330</b>		17. INFORMANT <b>Mrs. Louise G. Jones</b>
				ADDRESS <b>3707 Dennlyn Road</b>
18. <b>410.9 I</b> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) ASCVD</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRO VASCULAR ACCIDENT</b>				
19. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>11-23 1971</b> to <b>1-9 1972</b> that (I) (we) last saw the deceased alive on <b>1-9 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>1-9-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>PETER OROSZLAN MD</b>		23D. ADDRESS <b>3 HAMILL RD. APT 5</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		
25B. NAME OF REGISTRAR <b>Walter E. Jarboe, M.D.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		
		ADDRESS <b>3035 W. NORTH AVE.</b>		



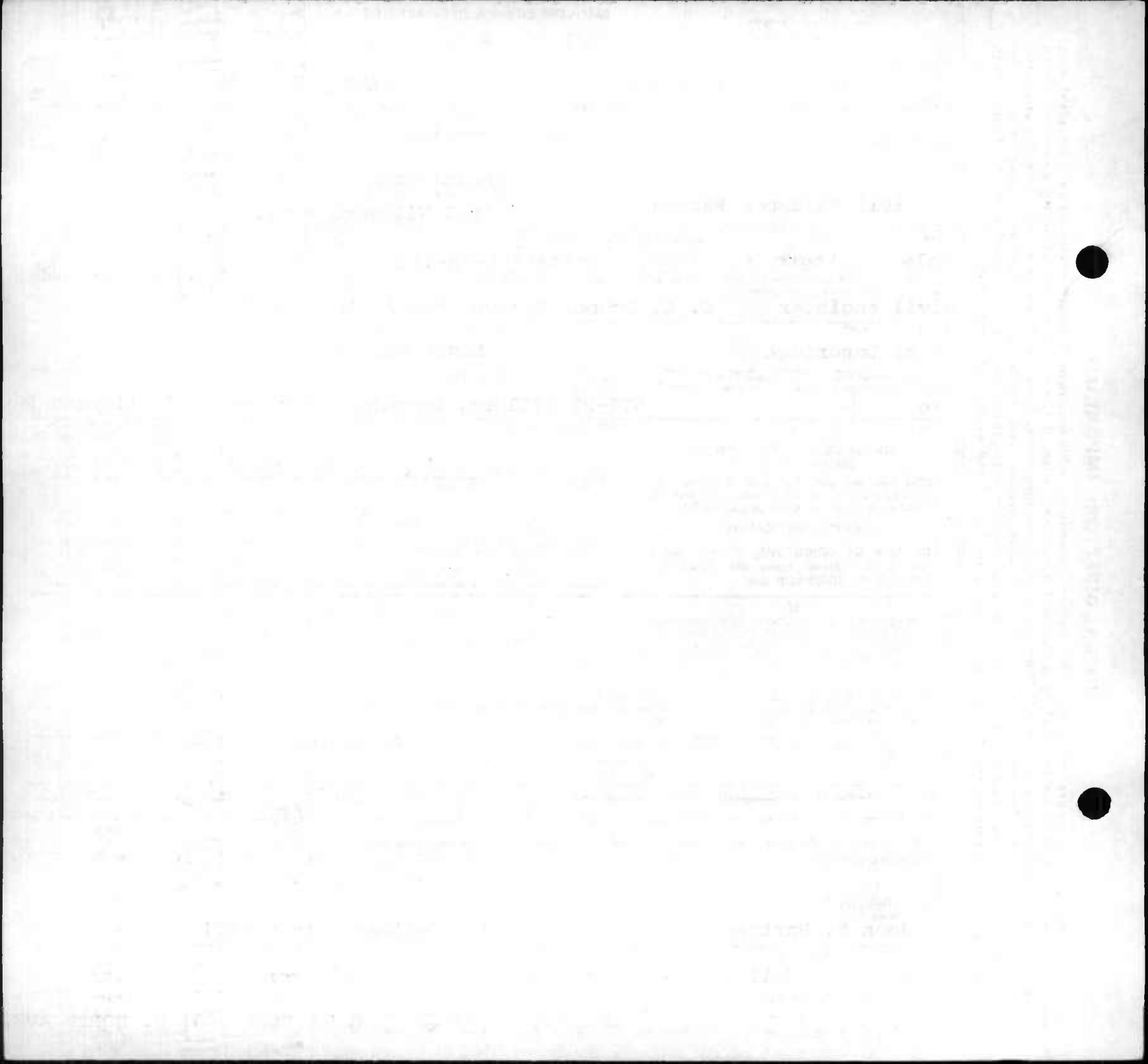
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

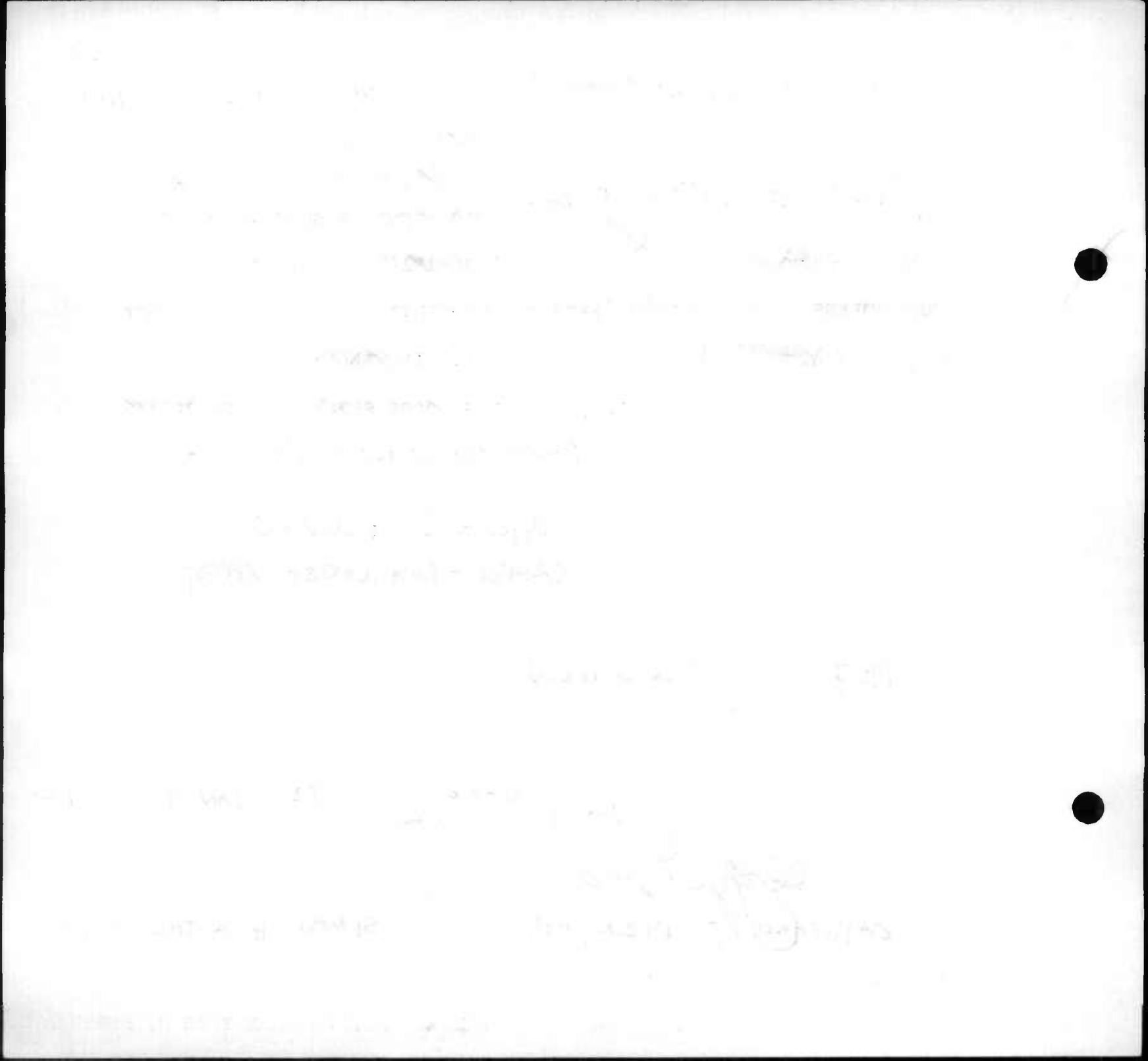
REG. NO. 72-00327

BIRTH NO. 72 00327		2. DATE AND HOUR OF DEATH January 7, 1972	
1. NAME OF DECEASED (Type or Print) Claude O. Dandridge		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1013 Wildwood Parkway		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1608 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1013 Wildwood Pkwy.	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-28-1889
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) civil engineer		10B. KIND OF BUSINESS OR INDUSTRY D. C. School System	9. AGE (In years last birthday) 82
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Dandridge		14. MOTHER'S MAIDEN NAME Susan Bailey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-5753	
17. INFORMANT Mrs. Dorothy Dandridge		ADDRESS 1013 Wildwood Pkwy	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ANTECEDENT CAUSES II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Renal Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Congestive Heart Failure 4 WKS (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD - Generalized (C) ANEMIA 4 WKS.	
19A. DATE OF OPERATION Dec. 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PROSTATE	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examination) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1971 to Jan. 7, 1972 that (I) (we) last saw the deceased alive on Jan 7, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John F. Hartman		23B. DATE SIGNED Jan 10, 1972	
23C. PHYSICIAN'S NAME (Type) John F. Hartman		23D. ADDRESS 422 Medical Arts Building	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-11-1972	
24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72-00328</u> <u>72-5724</u>
BIRTH NO. <u>72 00328</u>		2. DATE AND HOUR OF DEATH <u>JAN 9 1972</u> <u>11:00</u> M.		
1. NAME OF DECEASED (Type or Print) <u>ANNE BELL CHANDLER</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1538</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTO</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>5-30-1910</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HILLTOP CLEANERS</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLIE COLES</u>		
14. MOTHER'S MAIDEN NAME <u>LETTIE VAUGHN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>216-12-5665</u>		17. INFORMANT ADDRESS <u>MRS. ROSE SETH 3100 DENISON STREET</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF COLON W/METASTASIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Upper GI BLEEDING</u>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIO-RESPIRATORY ARREST</u>		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA OF COLON</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 6</u> 19 <u>72</u> <u>JAN 9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>JAN. 9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u> M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>DAVID T. DIZON, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-13-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL CEM.</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>		



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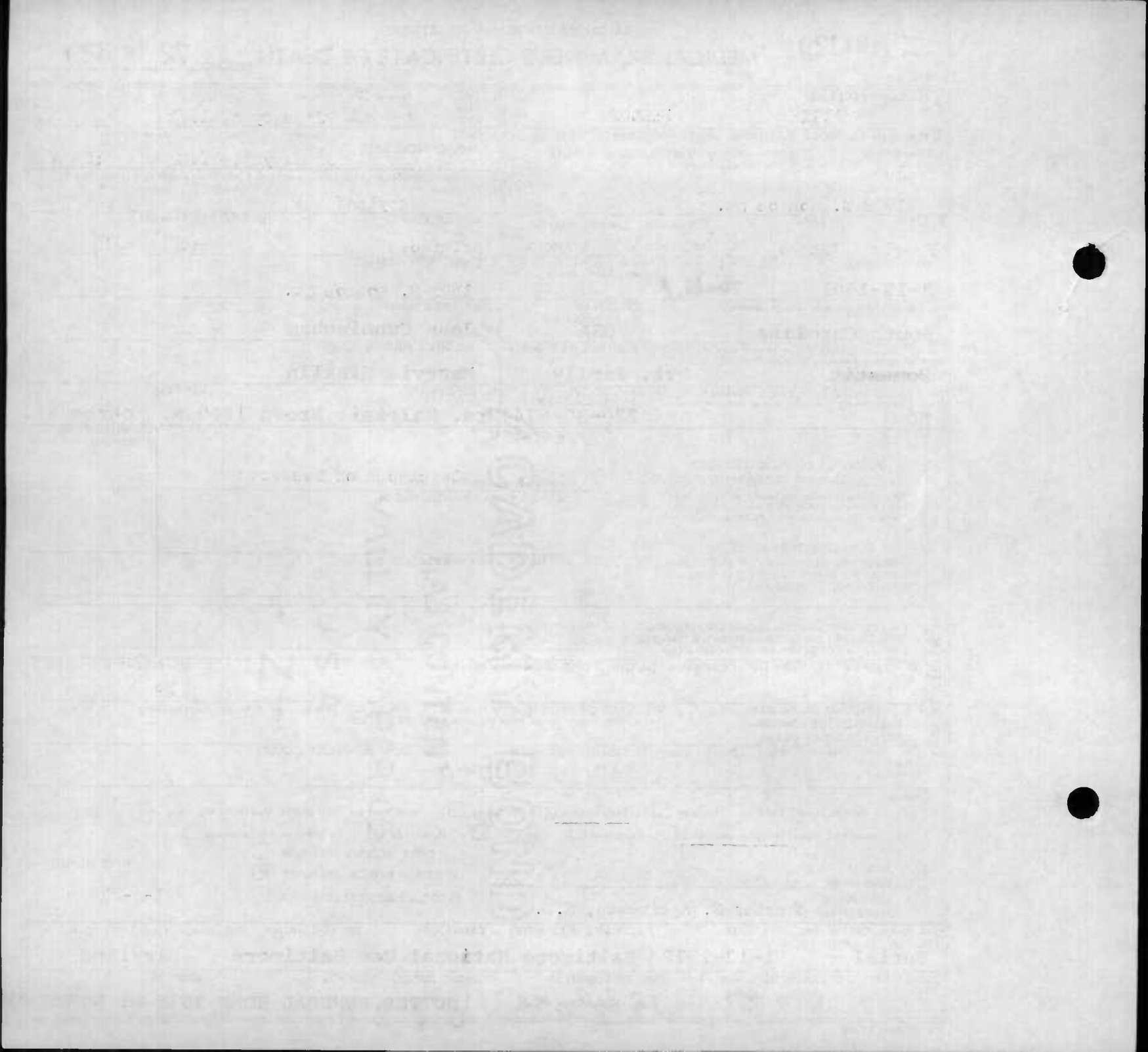
## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MATTIE</b> <b>FIELDS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>January 8, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1809 N. Monroe St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 8, 1972 1:35 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9-15-1901</b>		10. AGE (In years lost birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Cunningham</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1502</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>	
15. MOTHER'S MAIDEN NAME <b>Manevia Hinklin</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>220-30-6744</b>		18. INFORMANT <b>Mrs. Malessia Brown</b>	
19. <b>174X1</b>		ADDRESS <b>1809 N. Monroe St.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of breast</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-8-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AV</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F520 1		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00330
BIRTH NO. 72 00330		1. NAME OF DECEASED (Type or Print) <i>FINCH, MARY</i>		2. DATE AND HOUR OF DEATH <i>1-10-72 2:07 PM</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1511</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 HILTON NURSING HOME</i> <i>3313 POPLAR STREET BALTO MD</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>FEMALE</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>FARM</i>		8. DATE OF BIRTH <i>8-23-1864</i> 9. AGE (In years last birthday) <i>107</i>
11. BIRTHPLACE (State or foreign country) <i>RICHMOND, VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>? ?</i>		14. MOTHER'S MAIDEN NAME <i>SUSAN ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>479-66-1390</i>		17. INFORMANT <i>RUBY E. HATFIELD</i> ADDRESS <i>3406 HILTON ROAD</i>
18. <i>4-12-41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Coronary artery thrombosis.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerotic C-V Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>8/13</i> 19 <i>71</i> to <i>1/10</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1/10</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Alvin Thompson</i> MB DEGREE		23B. DATE SIGNED <i>1/10/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i> MB DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-14-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>ARBUTUS MEMORIAL PARK</i>
24D. LOCATION <i>BALTIMORE CO. MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 12 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>
25C. FUNERAL DIRECTOR <i>NUTTER FUNERAL HOME</i>		25D. ADDRESS <i>3035 W. NORTH AVE.</i>		

3-16-11 HILTON

1-16-11 HILTON

1-16-11

1-16-11

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00331

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH TAYLOR JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 9, 1972</b>		Hour <b>12:35 A.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 9, 1972</b>		Hour <b>12:35 A.M.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1603</b>				
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>4-26-1948</b>		10. AGE (In years last birthday) <b>23</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		E. STREET AND NUMBER <b>1106 N. Gilmore Street</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		15. FATHER'S NAME <b>Joseph Taylor Sr.</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME <b>Rosalee Dickerson</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs. Rosalee Taylor 1106 N. Gilmore St.</b>
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E9651</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>sidewalk</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>(found) in front of 1633 Pennsylvania Ave</b>
22D. TIME OF INJURY (APPROX.) <b>1-8-72 12:30 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>January 9, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>NUTTER, FUNERAL HOME 3035 W. NORTH AVE</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00332		REG. NO. 72 00332	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>McBane Willie</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>1-10-72 9<sup>45</sup> PM</i>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 Mt Sinai Nursing Home</i> <i>4376 PARK HEIGHTS AVE</i>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>B. COUNTY</b> <i>3023 EDDMAN AVE 833</i> <b>C. CITY OR TOWN</b> <b>D. INSIDE CITY LIMITS?</b> <i>BALTIMORE, MD</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b>			
<b>5. SEX</b> <i>M</i>	<b>6. RACE</b> <i>W</i>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>1-16-84</i>	<b>9. AGE</b> (In years last birthday) <i>87</i>	<b>If Under 1 Yr.</b> <b>Months</b> <b>Days</b>	<b>If Under 24 Hrs.</b> <b>Hours</b> <b>Min.</b>	<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>FARMER</i>
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>FARMING</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>N. CAROLINA</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <i>DAVID E. McBANE</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>JARAH JHAW</i>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) If yes, give war or dates of service <i>NO</i>		<b>16. SOCIAL SECURITY NO.</b> <i>237-05-8629</i>		<b>17. INFORMANT</b> <b>ADDRESS</b> <i>Lillian Losinsky Same 342-0893</i>			
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b>  <i>Adenocarcinoma of Rectosigmoid</i>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <i>ASCVD</i>  <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <i>CVA</i>  <b>(C)</b> </div> </div>							
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>							
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>12/23/71</i> <b>19</b> <i>to</i> <i>1/10</i> <b>19</b> <i>72</i> <b>that (I) (we) last saw the deceased alive on</b> <i>1/10</i> <b>19</b> <i>72</i> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <i>E. Skallins MD</i>				<b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <i>1/11/72</i>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>ESKALLINS MD</i>				<b>23D. ADDRESS</b> <i>6000 PARK HTS Dr Baltimore</i>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b>		<b>24D. LOCATION</b> (City, town, or county) (State)	
<i>BURIAL/REMOVAL</i>		<i>19 JAN 72</i>		<i>CHATHAM FRIENDS CHURCH</i>		<i>ALAMANCE COUNTY, N. C.</i>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>	
<i>JAN 12 1972</i>		<i>James E. ...</i>		<i>McClure Funeral Home</i>		<i>BALTIMORE, MD</i>	

MT Bane Willie 1-10-75 9pm  
3093 Edman Ave  
BALTIMORE MD

MT 2100 Park Heights Ave  
W M

1-10-84

Home 484-8034  
0000 Park Heights  
25-20-84

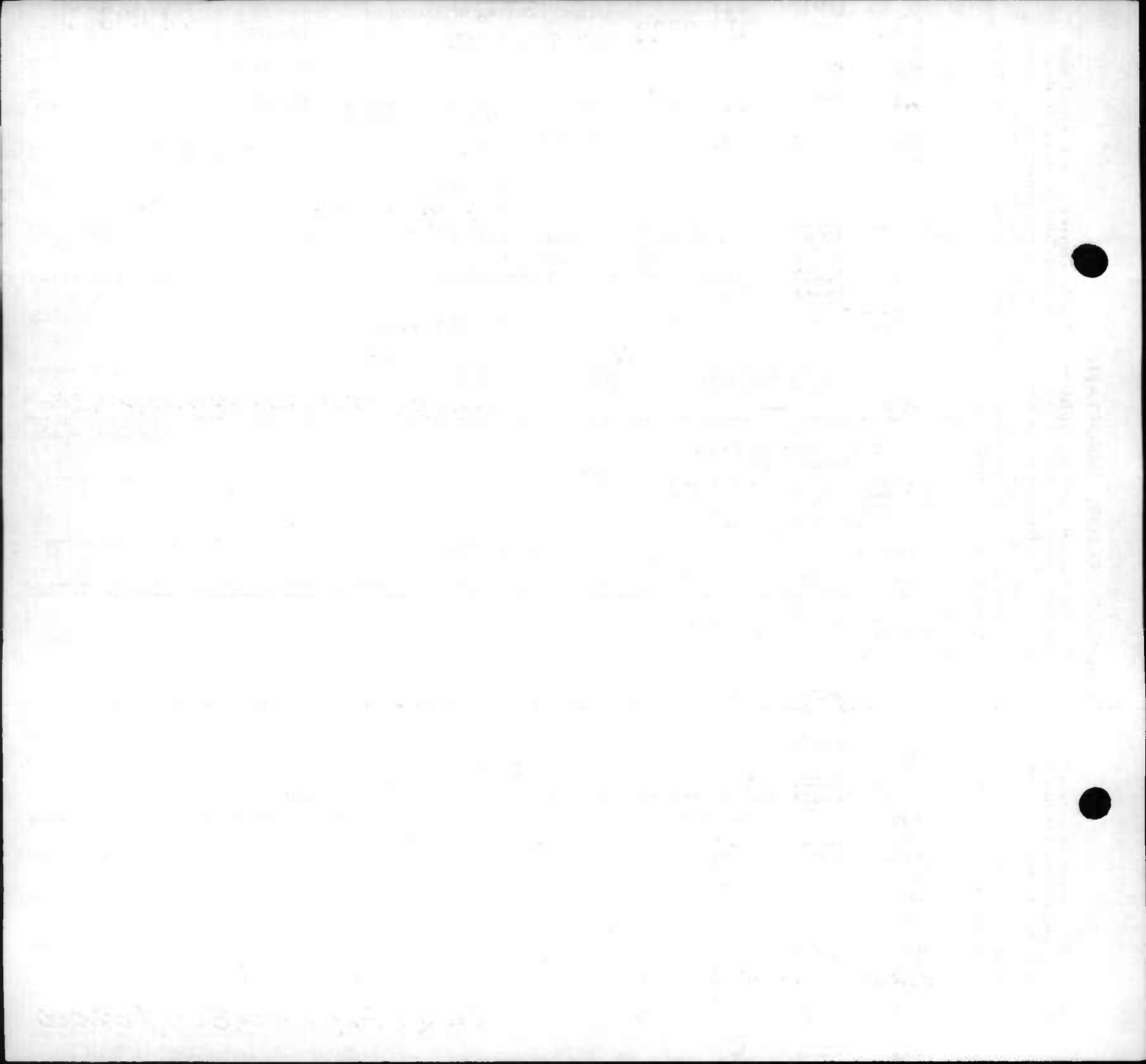
345-0013



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00333</span>	
C-140 72 00333				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARTHA W. COFIELD		1-11-72 6 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union MEMORIAL HOSPITAL				A. STATE MD	
				B. COUNTY 2731	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4104 HARRIS AVE	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-86	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN					
13. FATHER'S NAME JOHN R. WILKERSON				14. MOTHER'S MAIDEN NAME SARA MUHLY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT CHARLES J. PARR, 4104 HARRIS AVE. 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARDIAC ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRO VASCULAR ACCIDENT (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 1-7-72 to 1-11-72 that (I) (we) last saw the deceased alive on 1-11-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan M. Calderon				23B. DATE SIGNED 1-11-72	
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON				23D. ADDRESS VHH	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 12 1972		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEM.	
24D. LOCATION BALTO, MD.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR Charles J. Parr		25C. FUNERAL DIRECTOR Charles J. Parr	
25D. ADDRESS 4104 HARRIS AVE, BALTO, MD 21206					





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 73 00334	
C-620 72 00334				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARES, MADELINE M-		2. DATE AND HOUR OF DEATH 1-10-72 12:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto.		5300	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 31 Baltimore MD 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4940 Eastern Ave., Baltimore City Hospitals		21224	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1916	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel M Jenkins		14. MOTHER'S MAIDEN NAME Agnes I Baxley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-524		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 340X1 CAUSE OF DEATH (A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Paraplegia Nephrolithiasis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1971 to Jan 10 - 1972 that (I) (we) last saw the deceased alive on Jan 10 - 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Prakash G Sane M.D.				23B. DATE SIGNED Jan 10, 72	
23C. PHYSICIAN'S NAME (Type) Prakash G. Sane		23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224 Baltimore City Hospital, Balto, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/13/72		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR Robert E. J. B. Jr.		25C. FUNERAL DIRECTOR Leonard J. Buck Inc., Baltimore, Md.	

8308 Wilson ave  
last addn 11/23/71

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 72 00335		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00335	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BARBARA LEE BROOKS		January 8, 1972 7:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			B. COUNTY		
44 UNION MEMORIAL HOSPITAL			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			5302 Greenhill Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
female	caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 18, 1943	28	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William T. Brooks			Barbara J. Chetelat		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mr. William T. Brooks Same	
18. 343.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cerebro-Vascular accident		
			(C) Cerebral Birth Palsy		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			Sudden		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1972 to Jan 8 1972 that (I) (we) last saw the deceased alive on Jan 8 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. G. H. Baumgardner			1/10/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. G. H. Baumgardner			8552 Philadelphia Road		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/12/72		Most Holy Redeemer Cemetery	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 12 1972		Robert E. Jansen, M.D.		Donald J. Ruck, Inc. - Balto, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____	
K-320 72 00336				CERTIFICATE OF DEATH	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>JOSEPH H KOUTZ</b>		2. DATE AND HOUR OF DEATH <b>1/8/72 7:30 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>4+ UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2702</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4+ UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4316 WALTHER BLVD.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/1/88</b>	9. AGE (In years last birthday) <b>83</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ins. Agent</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH KOUTZ</b>			
14. MOTHER'S MAIDEN NAME <b>ANNA Vesser</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>215-05-1631</b>		17. INFORMANT <b>A Mrs Carrie M Koutz</b>			
18. CAUSE OF DEATH <b>RESPIRATORY INSUFFICIENCY</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This cause may be the immediate cause, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <b>CHIEF OR LAST MEDICAL EXAMINER</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>IT</b>		(C) _____			
19A. DATE OF OPERATION <b>12-18-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FRACURE RIGHT HIP</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4316 WALTHER BLVD 2702</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>12-18-71 ?</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/20/71</b> 19__ to <b>1/8/72</b> 19__ that (I) (we) last saw the deceased alive on <b>1/8/72</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. L. BUSTO</b>		23B. DATE SIGNED <b>1/8/72</b>		23C. PHYSICIAN'S NAME (Type) <b>R. L. BUSTO</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/12/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore, Md</b>	

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White  
Mrs. Jones

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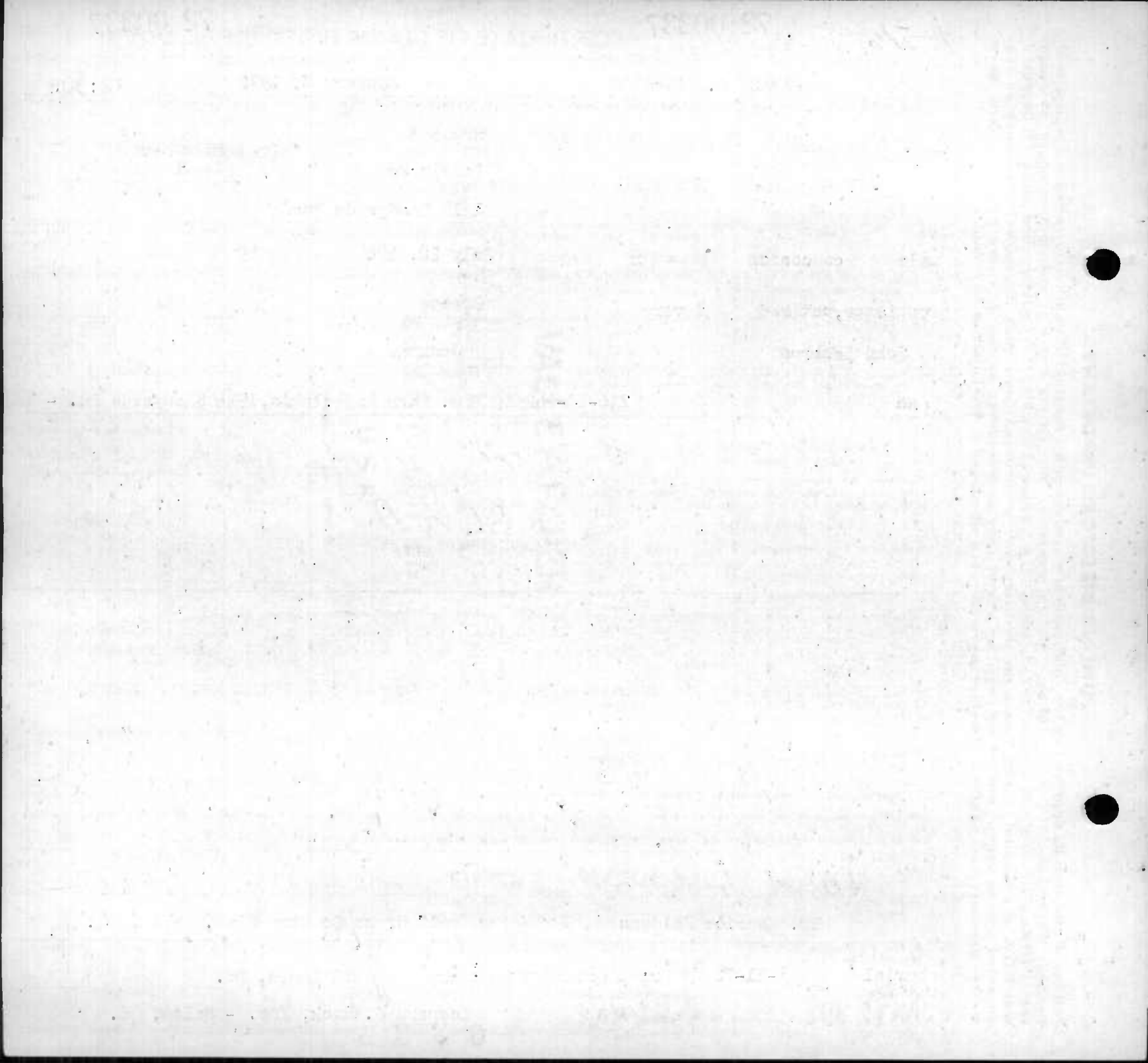
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00337</u>	
1. NAME OF DECEASED (Type or Print) <b>JAMES J. LAMBROS</b>				2. DATE AND HOUR OF DEATH <b>January 8, 1972</b>		<b>12:30P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>902</b>		C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>1514 Shadyside Road</b>			
5. SEX <b>male</b>	6. RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1886</b>		9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>proprietor, retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>taavern</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Lambros</b>				14. MOTHER'S MAIDEN NAME <b>Joanna</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>216-10-9425A</b>		17. INFORMANT <b>Mrs. Mary Maggelakis, 1514 Shadyside Rd. - 18</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>acute myocardial infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>15 yr</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>W</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>W</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> 19 <b>59</b> to <b>1/8</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>1/8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Maurice Feldman</b>				23B. DATE SIGNED <b>1/10/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Maurice Feldman</b>				23D. ADDRESS <b>6610 Cross Country Blvd, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1-11-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Greek Orthodox Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Feldman, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. - Balto, Md.</b>		ADDRESS	



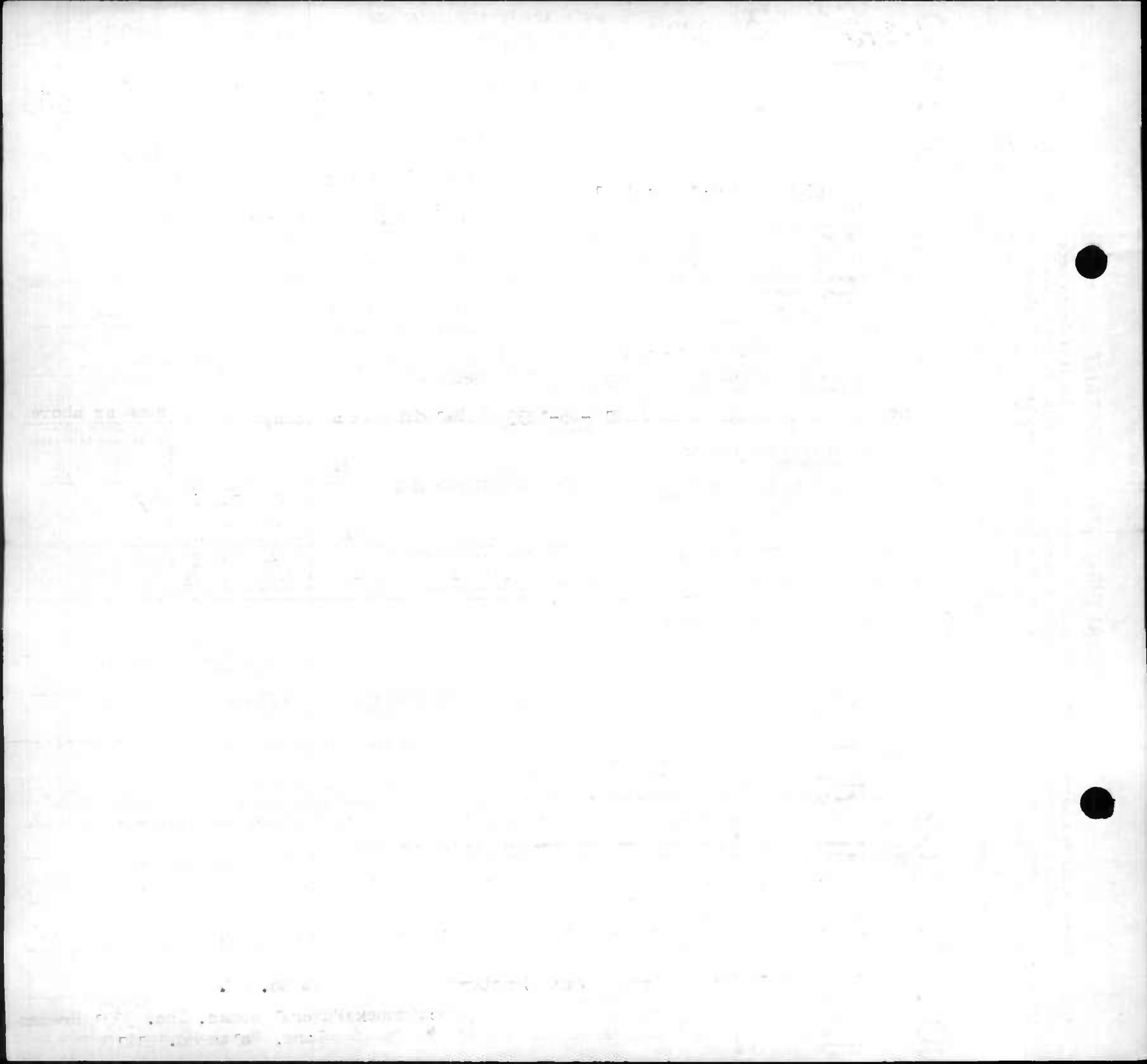




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

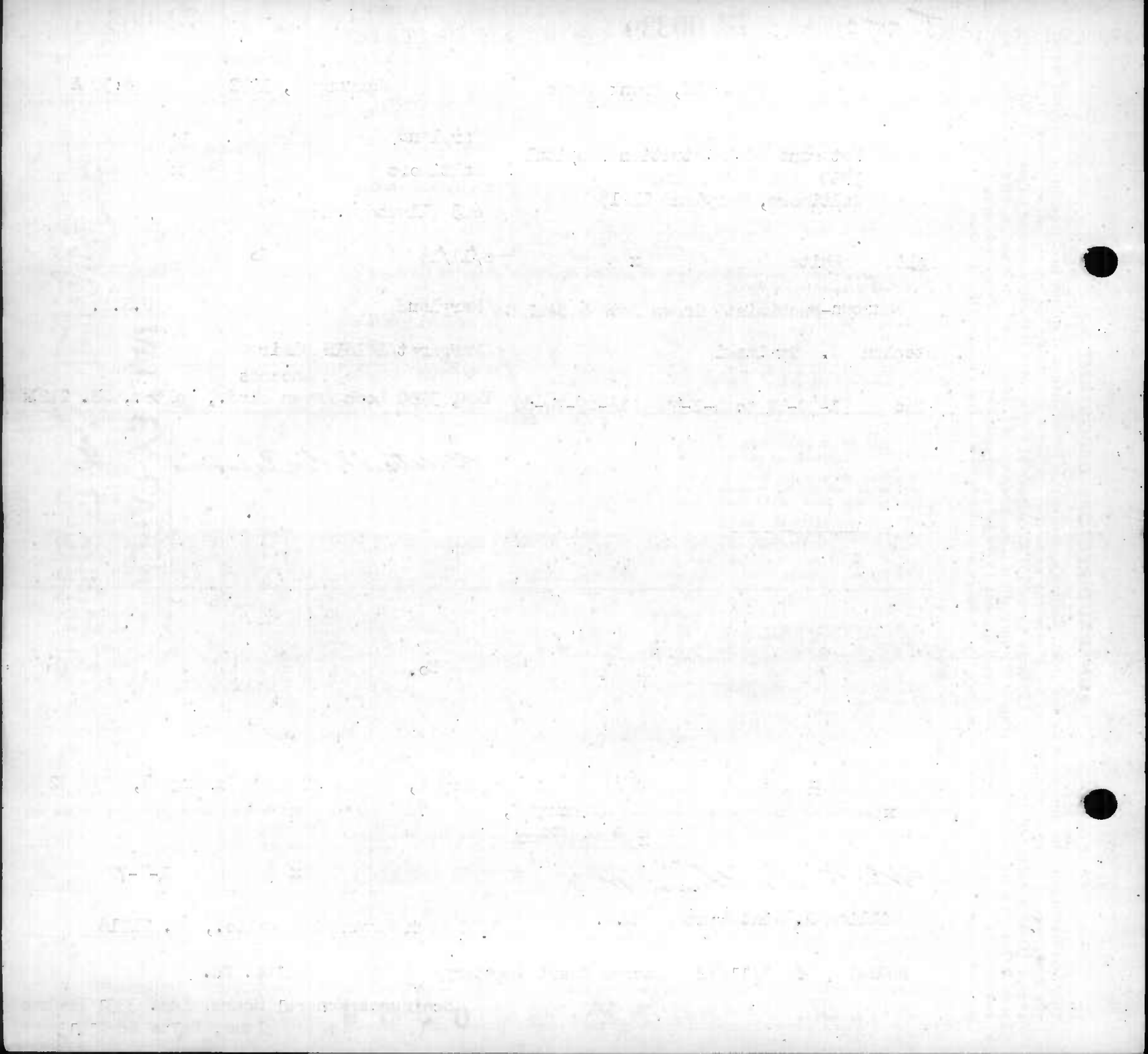
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00338</u>
W. 342 72 00338		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>CATHERINE E. WHITELOCK</u>		
2. DATE AND HOUR OF DEATH <u>January 7, 1972</u> <u>7:15 A.M.</u>		3. PLACE (IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2759</u>		
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1418 KINGSWAY ROAD</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09/21/98</u>	9. AGE (in years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>RETE MERZENFORD</u>		
14. MOTHER'S MAIDEN NAME <u>CATHERINE WAGNER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>215-05-1233</u>		17. INFORMANT <u>Melvin Dudeck (son)</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC DISEASE</u> <u>ADVANCED RECTAL CA</u>		19. CAUSE OF DEATH <u>4 days</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>				
21A. DATE OF OPERATION <u>0</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) <u>NO</u>
21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		
21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21G. DATE OF INJURY (Month) (Day) (Year) (Hour) <u>January 3, 1972</u>		
21H. TIME OF INJURY (APPROX.)		21I. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21J. HOW DID INJURY OCCUR?		21K. I certify that (I) (this hospital) attended the deceased from <u>January 3, 1972</u> to <u>January 7, 1972</u>		
21L. that (I) (we) lost saw the deceased alive on <u>January 7, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		21M. SIGNATURE <u>Ronald S. Carneiro</u>		
21N. DATE SIGNED <u>January 7, 1972</u>		21O. PHYSICIAN'S NAME (Type) <u>RONALDO S. CARNEIRO</u>		
21P. ADDRESS <u>33rd &amp; Calvert Sts - Balto - Md</u>		21Q. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		
21R. NAME OF REGISTRAR <u>John E. Johnson</u>		21S. NAME OF FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>		
21T. ADDRESS <u>3331 Brehms Lane, Balto Md. 21213</u>		21U. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21V. DATE <u>1/10/72</u>		21W. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21X. LOCATION <u>Balto. Md.</u>		21Y. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21Z. DATE <u>1/10/72</u>		21AA. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AB. LOCATION <u>Balto. Md.</u>		21AC. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21AD. DATE <u>1/10/72</u>		21AE. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AF. LOCATION <u>Balto. Md.</u>		21AG. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21AH. DATE <u>1/10/72</u>		21AI. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AJ. LOCATION <u>Balto. Md.</u>		21AK. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21AL. DATE <u>1/10/72</u>		21AM. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AN. LOCATION <u>Balto. Md.</u>		21AO. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21AP. DATE <u>1/10/72</u>		21AQ. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AR. LOCATION <u>Balto. Md.</u>		21AS. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21AT. DATE <u>1/10/72</u>		21AU. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AV. LOCATION <u>Balto. Md.</u>		21AW. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21AX. DATE <u>1/10/72</u>		21AY. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21AZ. LOCATION <u>Balto. Md.</u>		21BA. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BB. DATE <u>1/10/72</u>		21BC. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21BD. LOCATION <u>Balto. Md.</u>		21BE. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BF. DATE <u>1/10/72</u>		21BG. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21BH. LOCATION <u>Balto. Md.</u>		21BI. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BJ. DATE <u>1/10/72</u>		21BK. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21BL. LOCATION <u>Balto. Md.</u>		21BM. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BN. DATE <u>1/10/72</u>		21BO. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21BP. LOCATION <u>Balto. Md.</u>		21BQ. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BR. DATE <u>1/10/72</u>		21BS. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21BT. LOCATION <u>Balto. Md.</u>		21BU. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BV. DATE <u>1/10/72</u>		21BW. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21BX. LOCATION <u>Balto. Md.</u>		21BY. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21BZ. DATE <u>1/10/72</u>		21C0. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21C1. LOCATION <u>Balto. Md.</u>		21C2. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21C3. DATE <u>1/10/72</u>		21C4. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21C5. LOCATION <u>Balto. Md.</u>		21C6. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21C7. DATE <u>1/10/72</u>		21C8. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21C9. LOCATION <u>Balto. Md.</u>		21CA. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21CB. DATE <u>1/10/72</u>		21CC. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21CD. LOCATION <u>Balto. Md.</u>		21CE. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21CD. DATE <u>1/10/72</u>		21CF. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21CE. LOCATION <u>Balto. Md.</u>		21CF. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21CE. DATE <u>1/10/72</u>		21CF. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
21CE. LOCATION <u>Balto. Md.</u>		21CF. DATE OF REMOVAL (Specify) <u>BURIAL</u>		
21CE. DATE <u>1/10/72</u>		21CF. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

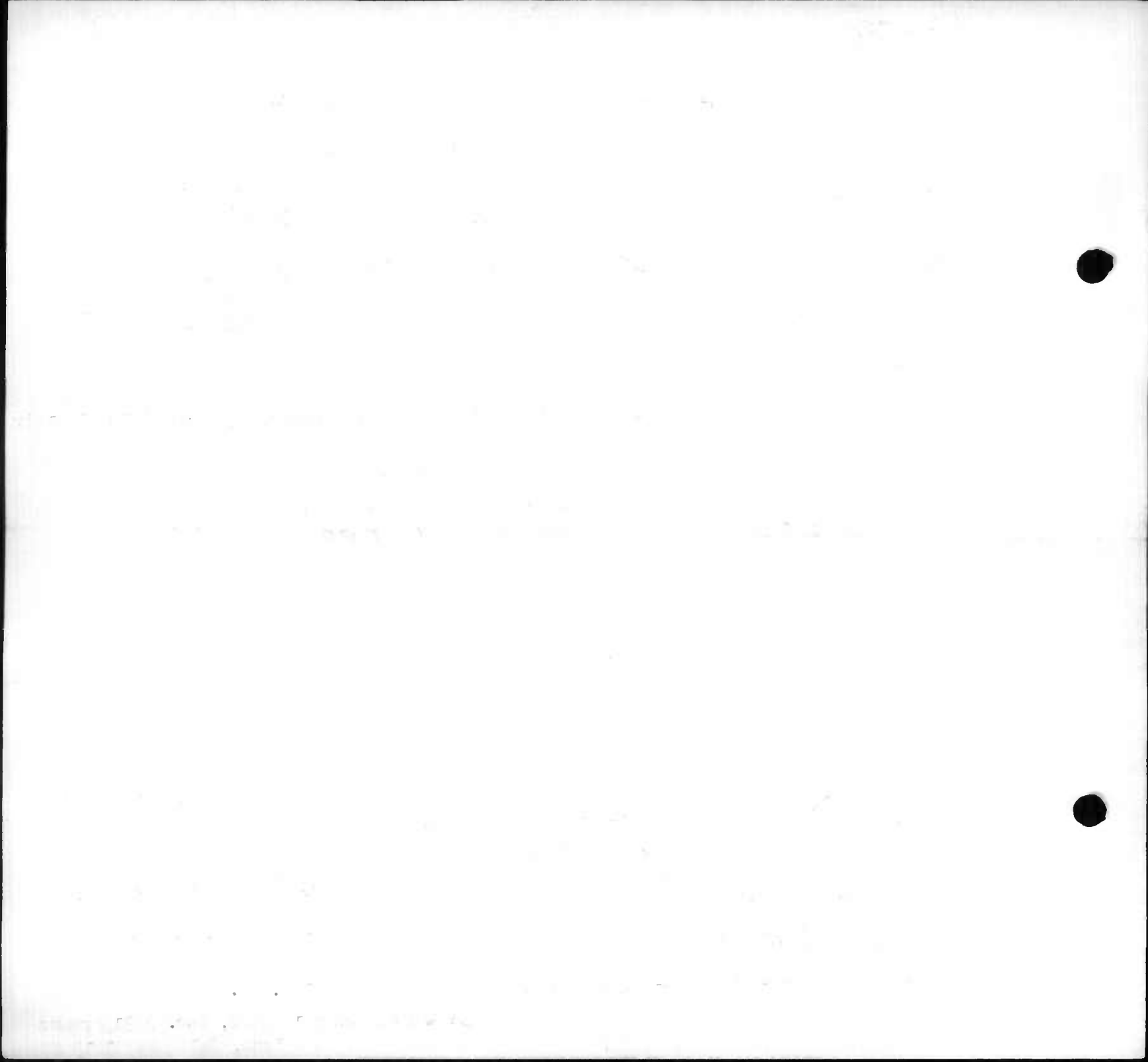
Baltimore City Health Department				REG. NO. 72 00339	
T-552		72 00339		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		TYMINSKI, Frank Steve		January 8, 1972 8:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		102	
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218		A. STATE Maryland		B. COUNTY	
23		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 603 Ellwood Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/15	9. AGE (In years last birthday) 56	10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown-Machinist		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Co		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stephen J. Tyminski		14. MOTHER'S MAIDEN NAME Margaret KALAK Blair	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1-30-42 to 4-1-44		16. SOCIAL SECURITY NO. 218-05-74-62		17. INFORMANT Records	
		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No.	
19C. DATE OF OPERATION 0		19D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from January 1, 1972 to January 8, 1972, that (we) last saw the deceased alive on January 8, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.		23A. SIGNATURE Wm. R. Linthicum M.D.		23B. DATE SIGNED 1-8-72	
23C. PHYSICIAN'S NAME (Type) William R. Linthicum M.D.		23D. ADDRESS 3900 Loch Raven Blvd Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/11/72		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 12 1972		25B. NAME OF REGISTRAR John E. Galt, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md 21213		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

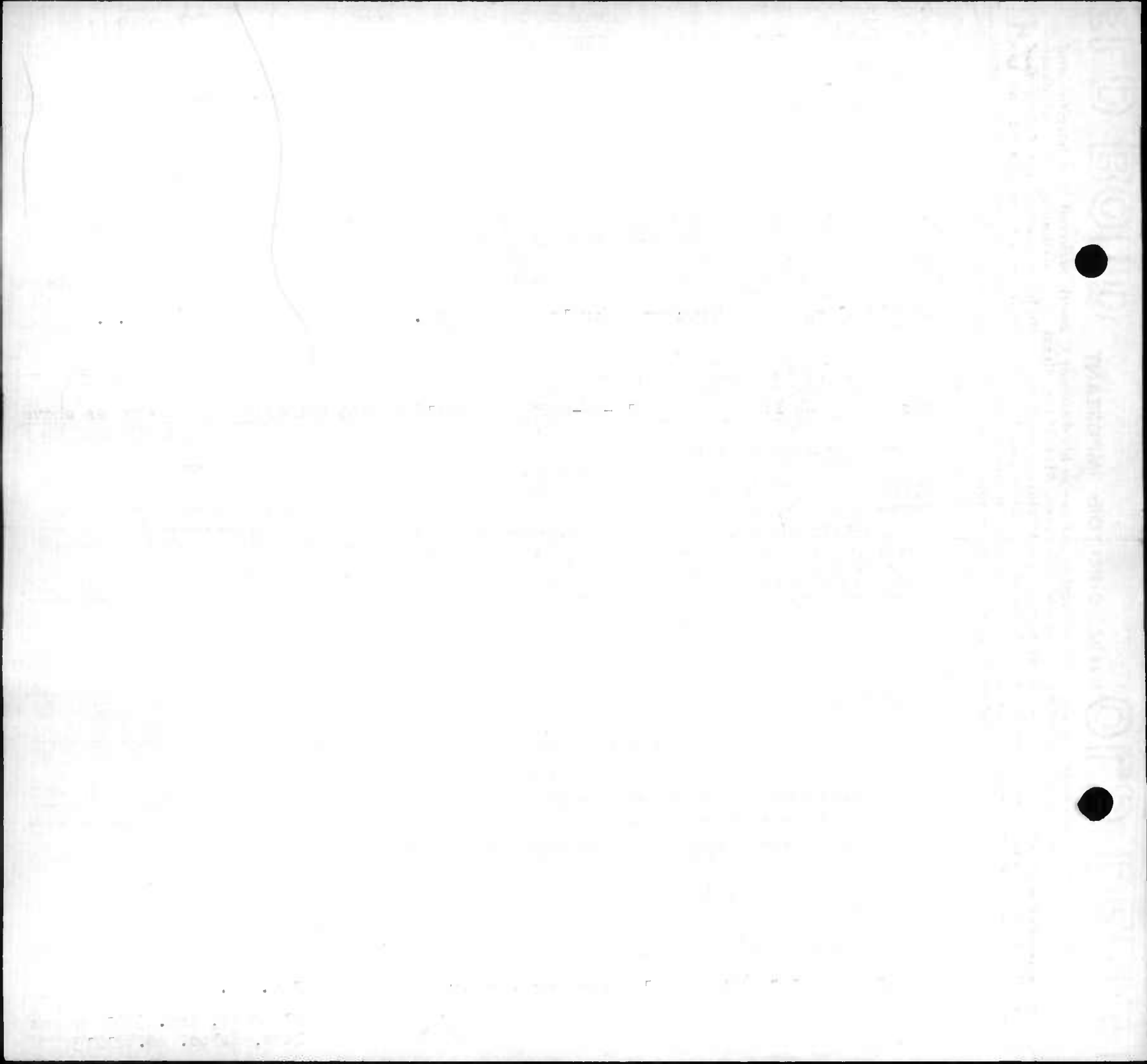
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00340</u>	
<b>BIRTH NO.</b> <u>E-536</u> <u>72 00340</u>					
<b>1. NAME OF DECEASED</b> (Type or Print) <u>JOHANNA ENPRES</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>1/9/72</u> <u>8.50</u> A.M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSP.</u> <u>43</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2652</u>		
			<b>C. CITY OR TOWN</b> <u>Baltimore</u>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			<b>E. STREET AND NUMBER</b> <u>4939 Sinclair Lane</u>		
<b>5. SEX</b> <u>Female</u>	<b>6. RACE</b> <u>W.</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-27-1892</u>	<b>9. AGE</b> (in years last birthday) <u>79</u>	If Under 1 Yr. Months:    Days:    If Under 24 Hrs. Hours:    Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Cuff</u>			<b>14. MOTHER'S MAIDEN NAME</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-05-6264-D</u>		<b>17. INFORMANT</b> <u>Joanne Oppenhauser (dghtr)</u>	
				ADDRESS <u>Lane</u> <u>4939 Sinclair</u>	
<b>18. CAUSE OF DEATH</b> <u>4/12/4 I</u>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Acute pulmonary edema</u> <u>ASCD. and CVA.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> <u>(X)</u> (this hospital) attended the deceased from <u>12-16</u> 19 <u>71</u> to <u>1-9</u> 19 <u>72</u> that <u>(X)</u> (we) last saw the deceased alive on <u>1-9</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did not) view the body after death.					
<b>23A. SIGNATURE</b> <u>Chiu Sung Chan</u>				<b>23B. DATE SIGNED</b> <u>Jan. 9, 72</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Chiu Sung Chan</u>				<b>23D. ADDRESS</b> <u>South Baltimore General Hospital</u>	
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>24B. DATE</b> <u>1/12/72</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Holy Redeemer Cemetery</u>	
				<b>24D. LOCATION</b> (City, town, or county) (State) <u>Balto. Md.</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 12 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>Rebecca J. ...</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Schmunek Funeral Homes, Inc.</u>	
				ADDRESS <u>3331 Brehms Lane, Balto Md 21213</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00341	
0-630 72 00341				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>FRANK J. ORTT</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 8 1972</u> <u>1:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>2633</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3444 GORDMAN AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-23-12</u>	9. AGE (in years last birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traffic Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Proctor &amp; Gamble</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>CHARLES ORTT</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes <u>WW II</u>		16. SOCIAL SECURITY NO. <u>213-05-6628</u>		17. INFORMANT <u>Madeline Ortt (wife)</u>	
18. <u>4/0.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>EAR MYOCARDIUM RUPTURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ANTERIOR MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIO SCLEROSIS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>71</u> to <u>1/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>De U. M. R.</u>				23B. DATE SIGNED <u>1/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DECAR VILVARON</u>				23D. ADDRESS <u>33rd. and Calvert ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/12/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		25B. NAME OF REGISTRAR <u>200</u>		25C. FUNERAL DIRECTOR <u>Schunmeyer Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-100		72 00342		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00342	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH R. CUFF</b>				2. DATE AND HOUR OF DEATH <b>1-11-72 12:10A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>903</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 MARYLAND GENERAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>623 E. 37th ST.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-23-1886</b>	9. AGE (In years last birthday) <b>85</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHIEF OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CO. C&amp;P TELEPHONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN T. CUFF</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH FLAHERTY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MISS MARY T. CUFF (SAME)</b>			
18. <b>437.21</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>CEASE-BRO - VASC INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Atherosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-26</b> 19 <b>71</b> to <b>1-11</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Michael Grassano</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL GRASSANO</b>				23D. ADDRESS <b>Grayland General</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/13/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>John H. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</b>			

100-1000

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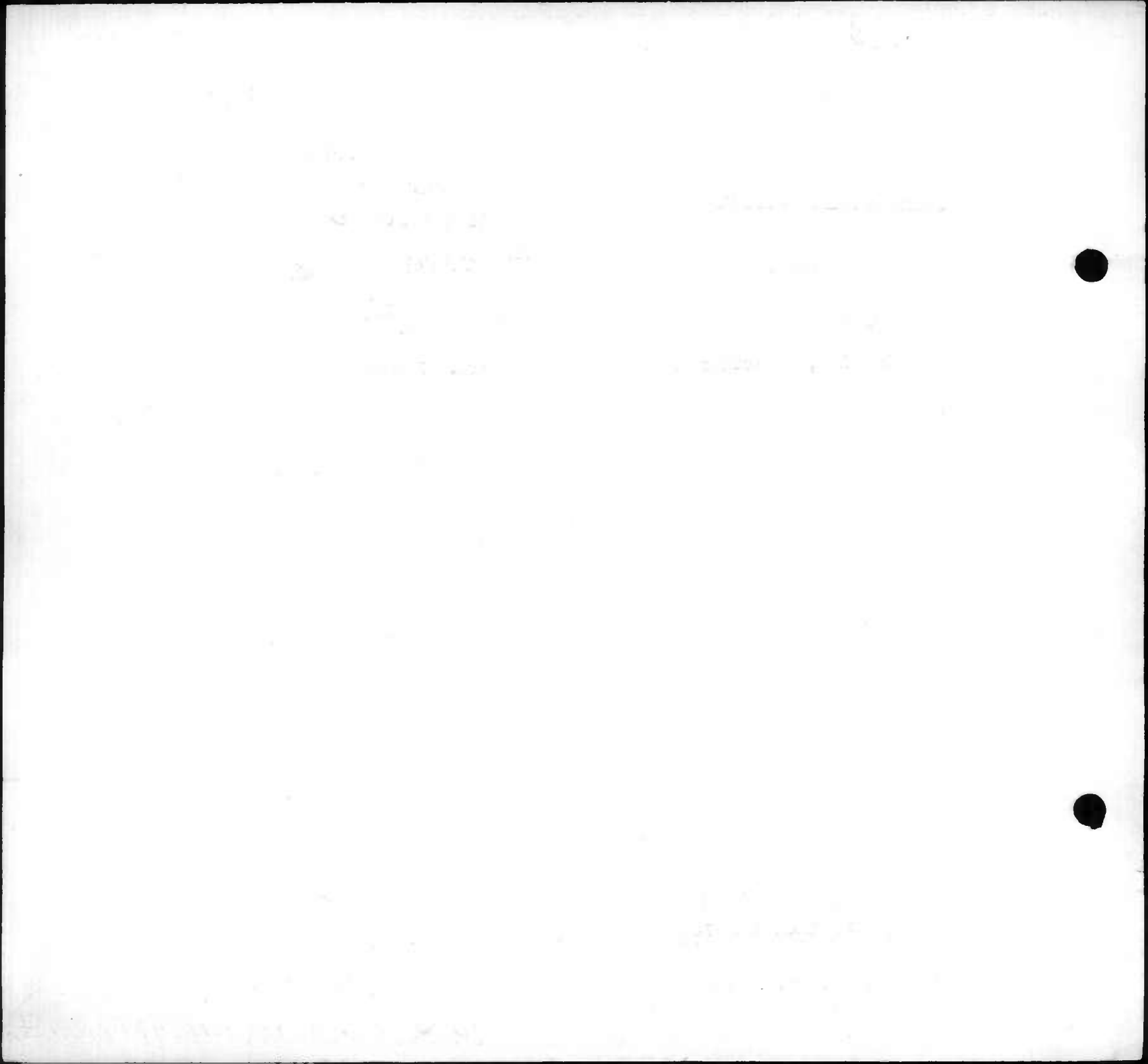
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00343</u>
BIRTH NO. <u>B-240</u>		72 00343		
1. NAME OF DECEASED (Type or Print) <u>Beasley, Stanley E.</u>		2. DATE AND HOUR OF DEATH <u>12:05 PM 1-8-72</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>805</u>		
5. SEX <u>MALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>10/9/13</u>		9. AGE (In years last birthday) <u>58</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Beasley, Arthur Lee</u>		
14. MOTHER'S MAIDEN NAME <u>Ware, lizzie</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W.W.II</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Myrl Hudson - 2311 Harford Rd.</u>		
18. ADDRESS		19. ADDRESS		
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>486 X1 ? Pulmonary Embolus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II ASCVD = severe peripheral vasc. disease</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia, COPD, Atrial Fibrillation</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		23. DATE OF OPERATION <u>0</u>		
24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No)		
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
30. INJURY OCCURRED		31. HOW DID INJURY OCCUR?		
32. I certify that (1) (this hospital) attended the deceased from <u>1-6-72</u> to <u>1-8-72</u> and that (2) (we) last saw the deceased alive on <u>1-8</u> 19 <u>72</u> and that (3) (my) (your) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		33. SIGNATURE <u>George J. Taylor</u> MD		
34. PHYSICIAN'S NAME (Type) <u>George J. Taylor</u>		35. DATE SIGNED		
36. PHYSICIAN'S DEGREE <u>MD</u>		37. ADDRESS <u>Johns Hopkins Hospital Baltimore, Md.</u>		
38. PHYSICIAN'S DEGREE <u>MD</u>		39. ADDRESS <u>Bowling Green Va.</u>		
40. BURIAL, CREMATION, REMOVAL (Specify)		41. DATE		
42. NAME OF CEMETERY OR CREMATORY		43. LOCATION (City, town, or county) (State)		
44. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1972</u>		45. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		
46. DATE REC'D BY HEALTH DEPT.		47. NAME OF REGISTRAR		
48. DATE REC'D BY HEALTH DEPT.		49. NAME OF REGISTRAR		
50. DATE REC'D BY HEALTH DEPT.		51. NAME OF REGISTRAR		
52. DATE REC'D BY HEALTH DEPT.		53. NAME OF REGISTRAR		
54. DATE REC'D BY HEALTH DEPT.		55. NAME OF REGISTRAR		
56. DATE REC'D BY HEALTH DEPT.		57. NAME OF REGISTRAR		
58. DATE REC'D BY HEALTH DEPT.		59. NAME OF REGISTRAR		
60. DATE REC'D BY HEALTH DEPT.		61. NAME OF REGISTRAR		
62. DATE REC'D BY HEALTH DEPT.		63. NAME OF REGISTRAR		
64. DATE REC'D BY HEALTH DEPT.		65. NAME OF REGISTRAR		
66. DATE REC'D BY HEALTH DEPT.		67. NAME OF REGISTRAR		
68. DATE REC'D BY HEALTH DEPT.		69. NAME OF REGISTRAR		
70. DATE REC'D BY HEALTH DEPT.		71. NAME OF REGISTRAR		
72. DATE REC'D BY HEALTH DEPT.		73. NAME OF REGISTRAR		
74. DATE REC'D BY HEALTH DEPT.		75. NAME OF REGISTRAR		
76. DATE REC'D BY HEALTH DEPT.		77. NAME OF REGISTRAR		
78. DATE REC'D BY HEALTH DEPT.		79. NAME OF REGISTRAR		
80. DATE REC'D BY HEALTH DEPT.		81. NAME OF REGISTRAR		
82. DATE REC'D BY HEALTH DEPT.		83. NAME OF REGISTRAR		
84. DATE REC'D BY HEALTH DEPT.		85. NAME OF REGISTRAR		
86. DATE REC'D BY HEALTH DEPT.		87. NAME OF REGISTRAR		
88. DATE REC'D BY HEALTH DEPT.		89. NAME OF REGISTRAR		
90. DATE REC'D BY HEALTH DEPT.		91. NAME OF REGISTRAR		
92. DATE REC'D BY HEALTH DEPT.		93. NAME OF REGISTRAR		
94. DATE REC'D BY HEALTH DEPT.		95. NAME OF REGISTRAR		
96. DATE REC'D BY HEALTH DEPT.		97. NAME OF REGISTRAR		
98. DATE REC'D BY HEALTH DEPT.		99. NAME OF REGISTRAR		
100. DATE REC'D BY HEALTH DEPT.		101. NAME OF REGISTRAR		



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CLARENCE MOBLEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 8, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour January 8, 1972 6:33 A.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-4-20</b>		10. AGE (In years last birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Mobley</b>		14. MOTHER'S MAIDEN NAME <b>Thelie Padgett</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Worker Construction</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>412-41</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7. K.</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-8-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Hopkintown, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. Clark</b>	
25C. FUNERAL DIRECTOR <b>Milton G. Chalkin</b>		ADDRESS <b>1129 N. Caroline St.</b>	

PATIENT'S NAME		DATE OF BIRTH	
SEX		AGE	
RACE		RELIGION	
MARITAL STATUS		OCCUPATION	
EDUCATION		MILITARY SERVICE	
PREVIOUS MENTAL ILLNESS		CURRENT MENTAL ILLNESS	
SUBSTANCE ABUSE		PHYSICAL ILLNESS	
SOCIAL HISTORY		FAMILY HISTORY	
MENTAL STATUS		DIAGNOSIS	
TREATMENT		PROGNOSIS	
REMARKS		SIGNATURE	
DATE		TIME	

R-420

72 00345

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00345

BIRTH NO. 68-24389

1. NAME OF DECEASED  
(Type or Print)

KEVIN ROLES

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

8:55 p M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Md.

B. COUNTY

CERTIFICATE AMENDED

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-24-68

10. AGE (In years  
last birthday)

3

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3433 Chessel Ct.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jerry Roles

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Kathleen Brown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Kathleen Roles 3433 Chessel Ct.

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Multiple traumatic injuries with terminal  
aspiration of gastric contents

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

3433 Chessel Ct.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

1-8-72

P. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Struck by mother

Undetermined

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-10-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-14-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State)

A. A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 12 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Robert E. Fisher, M.D. 1129 N. Carroll St.



2-16-1972 - Form - completion of cause of death on a pending medical examiner death  
certificate - Russell S. Fisher, M.D. (Unpending 2-15-72)  
HRS

3-16-1972 - Letter - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

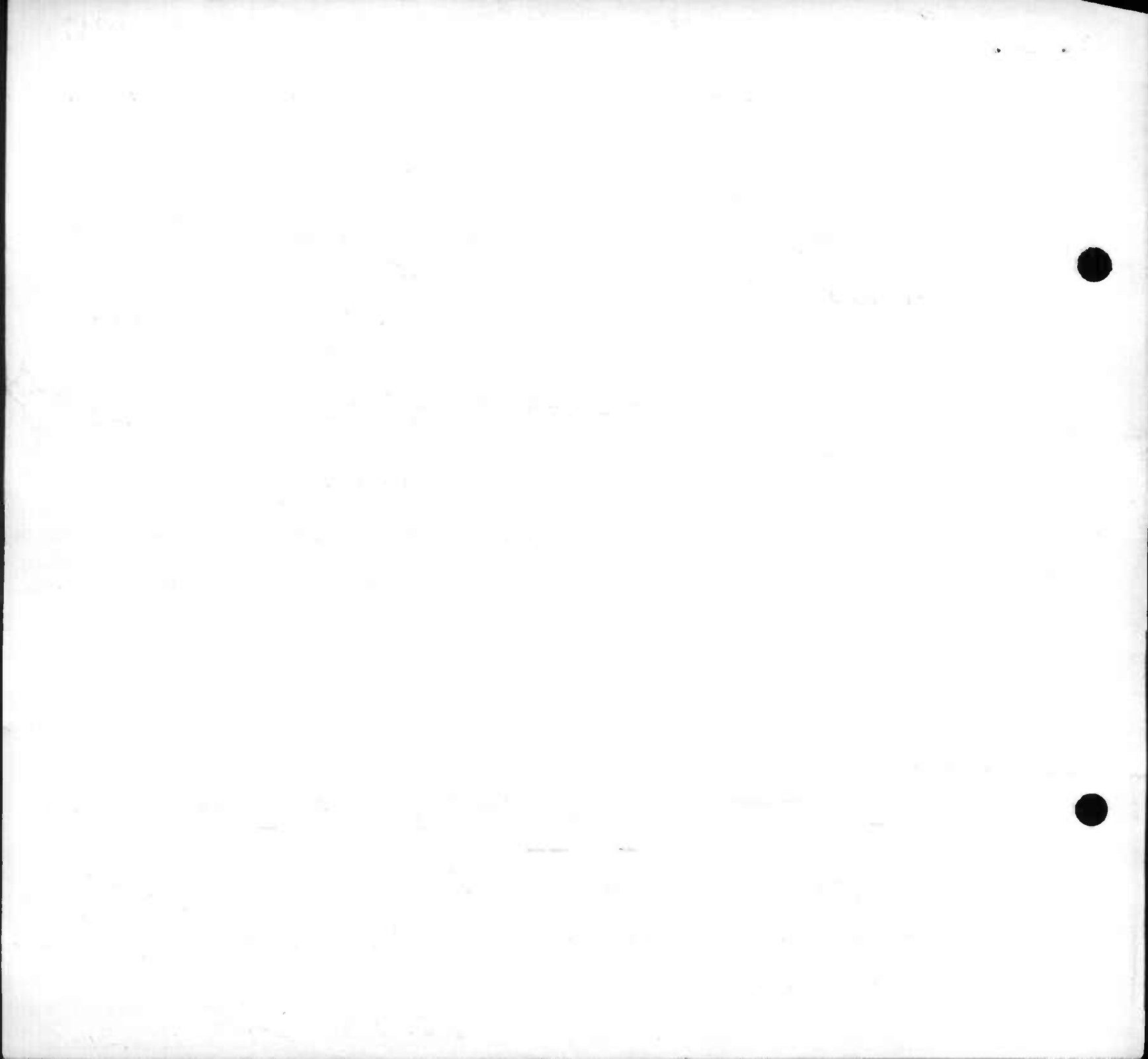
HRS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

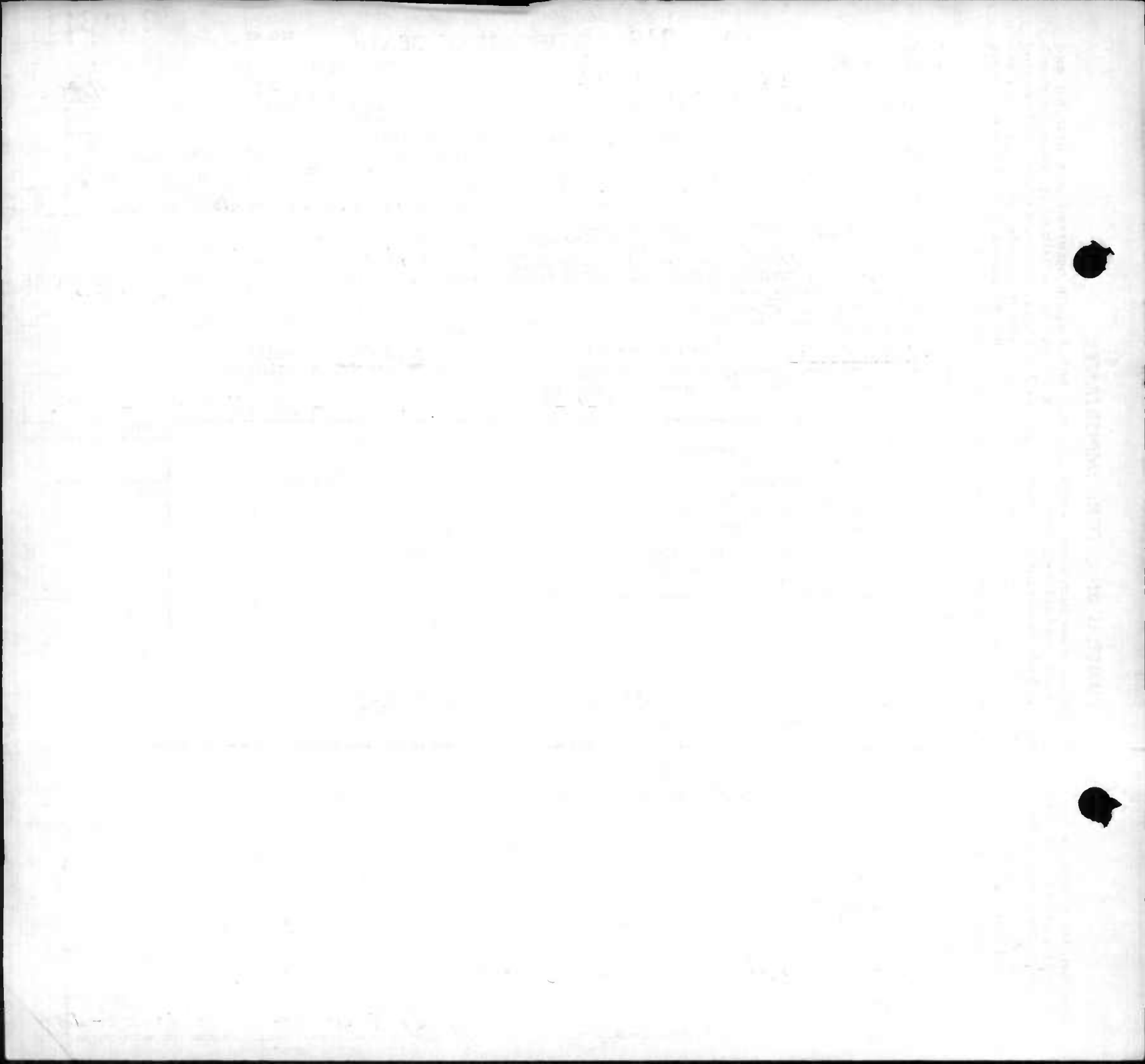
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>12 00347</u>	
<u>R-250</u> BIRTH NO. <u>12 00347</u>		1. NAME OF DECEASED (Type or Print) <u>Alice S. Rosen</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>4435 Mannasota Avenue</u>		2. DATE AND HOUR OF DEATH <u>January 8, 1972</u> <u>9:30 A.</u> M.  4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2642</u>  C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER <u>4435 Mannasota Avenue-21213</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1902</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. City</u>	
13. FATHER'S NAME <u>Lemuel Ayres</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Webb</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-5101</u>		17. INFORMANT ADDRESS <u>Alyce S. Price 4435 Mannasota Ave. -21206</u>	
18. <u>410.91</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>ACUTE CORONARY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF:  <u>CORONARY ATHEROSCLEROSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF:  <u>DIABETES MELLITUS</u> (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 HOUR</u>  <u>SEVERAL YEARS</u>  <u>RECENT MONTHS</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>12/28</u> 19 <u>71</u> to <u>1/8</u> 19 <u>72</u> that (I) <del>(we)</del> last saw the deceased alive on <u>1/5</u> 19 <u>72</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>Albert C. Herrmann, M.D.</u> DEGREE				23B. DATE SIGNED <u>1/10/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALBERT C. HERRMANN, M.D.</u> DEGREE				23D. ADDRESS <u>5525 BELAIR ROAD, BALTO. MD. 21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-11-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. LOCATION (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. J. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>John J. Ailler Inc-415 Belair Rd. 21206</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">2 00348</span>	
BIRTH NO. <span style="font-size: 1.5em;">M-500</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARY E. MUMMA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">11/8/72</span> <span style="float: right;">11:30 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">THE UNION MEMORIAL HOSPITAL</span>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2642</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">4215 Nicholas Avenue</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">June 10, 1895</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">76</span>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. S.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">UNKNOWN Thomas Jordan</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY GRAY</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-16-3912</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Harry R. Mumma - 3224 Lake Avenue - Balto. Md.</span>		
18. <span style="font-size: 1.2em;">412.41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">CEREBROVASCULAR ACCIDENT</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">THROMBOSIS OF RIGHT SILVIAN ARTERY</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">19</span> to <span style="font-size: 1.2em;">19</span> that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">JOSE PAZ</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">1/8/72</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOSE PAZ</span>				23D. ADDRESS <span style="font-size: 1.2em;">THE UNION MEMORIAL HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1-11-72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Moreland Memorial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE OF HEALTH DEPT. REGISTRATION <span style="font-size: 1.2em;">JAN 13 1972</span>				25B. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John J. Miller Inc.</span>		25C. ADDRESS <span style="font-size: 1.2em;">6415 Belair Road-21206</span>	



B-260 72 00349 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN BAKER, JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 7 or 8, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1808 N. Calvert Street 2-14-72</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 8, 1972 10:45 A.</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1205</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>April 21, 1921</b>	10. AGE (In years last birthday) <b>50</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Baker, Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Short Order Cook</b>	
15. MOTHER'S MAIDEN NAME <b>Debbie Staton</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W.II</b>	
17. SOCIAL SECURITY NO. <b>226-24-6107</b>		18. INFORMANT ADDRESS <b>William Lankford 6206 Alomore Way 21224</b>	

19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/2/4</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION <b>2</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>	ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	<b>January 9, 1972</b>	

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/12/1972</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Gettysburg National Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Gettysburg, Pennsylvania</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>LORING BYERS</b>	ADDRESS <b>8728 Liberty Rd. Md. 21133</b>

2-14-1972 - Correction Form from Funeral Director.

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>K-460</u> <u>72 00350</u>				CITY HEALTH DEPARTMENT		REG. NO. <u>72 00350</u>	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>(CHAMPION) KELLER Charlotte</u>				2. DATE AND HOUR OF DEATH <u>January 10, 1972</u> <u>1</u> <u>1</u> <u>P.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY <u>2611</u>	
<u>BALTIMORE CITY HOSPITAL 21224</u>		<u>4940 Eastern Avenue Baltimore, Maryland</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3230 O'Donnell Street 21224</u>							
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-92</u>	9. AGE (in years last birthday) <u>79</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Wm. S. HART</u>			14. MOTHER'S MAIDEN NAME <u>Marie ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>219-22-4592A</u>		17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS <u>BCH: Records Baltimore, Maryland 21224</u>		
18. <u>410.91</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Arteriosclerotic Cardio-Vascular Disease.</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>cholecystectomy</u>							
19A. DATE OF OPERATION <u>12/14/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>December 12</u> 19 <u>71</u> to <u>January 10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>January 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Eduardo Barboza, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 10, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDUARDO BARBOZA, M.D.</u>				23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/13/72</u>		24C. NAME of CEMETERY or CREMATORY <u>LOUDON PARK</u>		24D. LOCATION (City, town, or county) <u>BALTO. MD.</u> <u>151st</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>John E. Connelly</u>		25C. FUNERAL DIRECTOR <u>J. E. CONNELLY</u>		ADDRESS <u>300 MACE</u>	

(103) 574-15

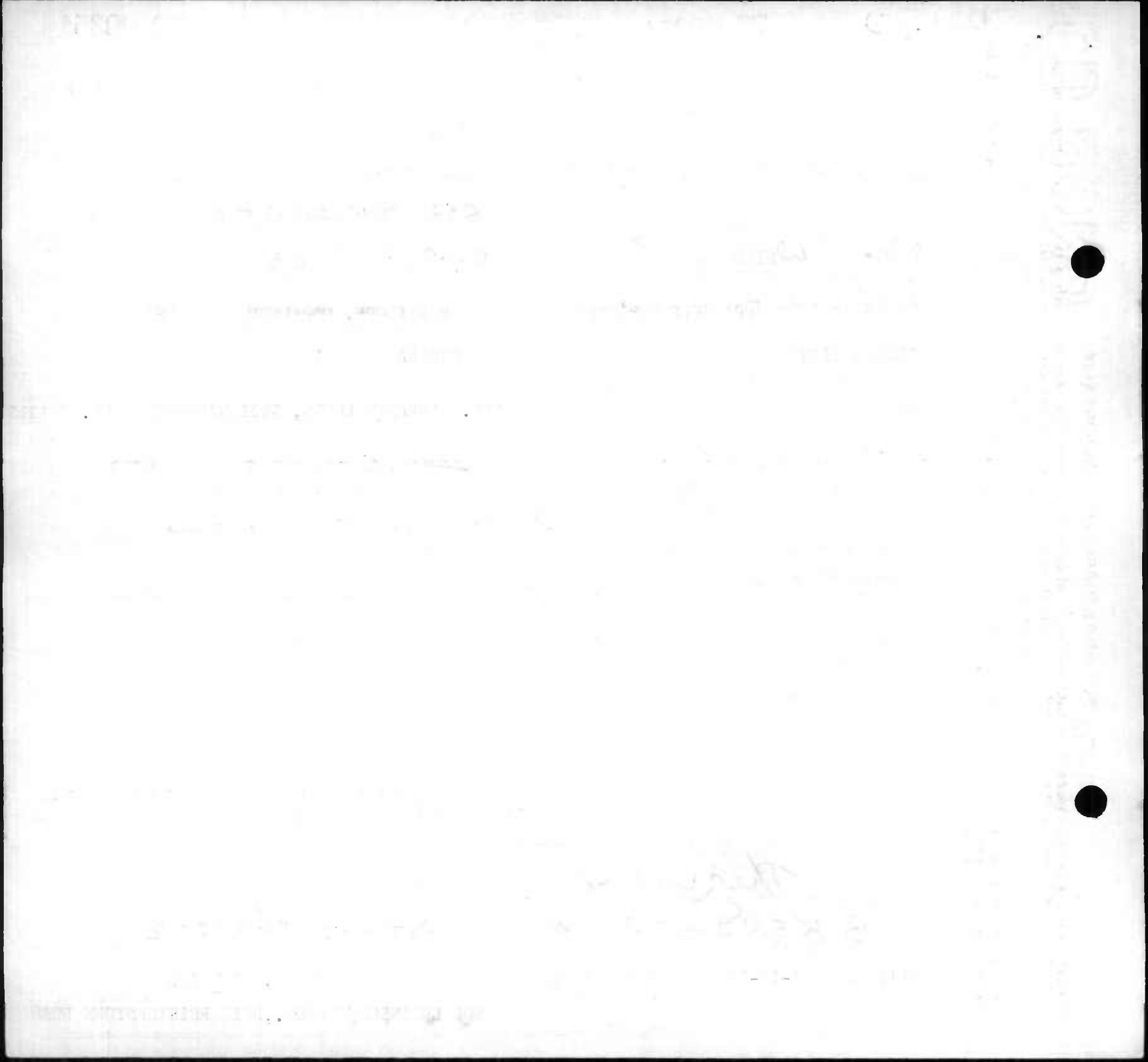




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00351	
CERTIFICATE OF DEATH					
BIRTH NO. L-150		72 00351			
1. NAME OF DECEASED (Type or Print) <b>LEVIN, ISADORE E.</b>			2. DATE AND HOUR OF DEATH <b>1/11/72 1059 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2719</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b> <b>42</b>			C. CITY OR TOWN <b>BALTIMORE.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>5821 NARCISSUS AVE. 21215.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02/20/08</b>	9. AGE (In years last birthday) <b>63.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT TCPA</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>MEDEL LEVIN</b>		
14. MOTHER'S MAIDEN NAME <b>STELLA ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>MRS. FLORENCE LEVIN, 5821 NARCISSUS AVE. #21215</b>		
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY INSUFFICIENCY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>01/09/72</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RESPIRATORY INSUFFICIENCY</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>VRS</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCURRED</b>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>01/11/72</b>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>01/09/72</b> to <b>01/11/72</b> that (I) (we) lost saw the deceased alive on <b>01/11/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. KERZNER MD</b>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>B. KERZNER MD</b>			23D. ADDRESS <b>SINAI HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>1-12-72</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>			25B. NAME OF REGISTRAR <b>SOL LEVINSON</b>		
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72-00352</u>	
<p><b>BIRTH NO.</b> <u>P-225</u></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <u>MAX E. PUSHKIN</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <u>1-10-72</u> <u>8:10 P.M.</u></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSP. OF BALTO</u> <u>42</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> <u>2740</u></p> <p>C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>5823 WESTERN RUN DR</u></p>			
<p><b>5. SEX</b> <u>Male</u></p>	<p><b>6. RACE</b> <u>White</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>10/5/10</u></p>	<p><b>9. AGE</b> (In years lost birthday) <u>61</u></p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CREDIT MANAGER</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>HOWARD ST. JEWELERS</u></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>RUSSIA</u></p>	
<p><b>13. FATHER'S NAME</b> <u>JACOB PUSHKIN</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <u>RACHEL ?</u></p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT</b> ADDRESS <u>MRS. EVELYN PUSHKIN, 5823 B WESTERN RUN DR., #9</u></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCT</u></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Long standing Arteriosclerotic Cardiovasc. Disease with numerous episodes of coronary insufficiency and several previous Myocardial Infarctions</u></p>		<p><b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Long standing Arteriosclerotic Cardiovasc. Disease with numerous episodes of coronary insufficiency and several previous Myocardial Infarctions</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>previous Myocardial Infarctions</u></p> <p>(C) <u>previous Myocardial Infarctions</u></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>INSTANTANEOUS</u></p>			
<p><b>MEDICAL CERTIFICATION</b></p> <p><b>19A. DATE OF OPERATION</b> <u>0</u> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p> <p><b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p> <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p> <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b></p> <p><b>22. I certify that (1) (this hospital) attended the deceased from Approx 15 to 16 yrs. to 1-10-1972 that (1) (we) last saw the deceased alive on 12-24-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p> <p><b>23A. SIGNATURE</b> <u>Joseph Deckelbaum, M.D.</u> <b>23B. DATE SIGNED</b> <u>1-10-72</u></p> <p><b>23C. PHYSICIAN'S NAME (Type)</b> <u>JOSEPH DECKELBAUM, M.D.</u> <b>23D. ADDRESS</b> <u>3502 WEST PETERS AVE. BALTO. MD. 2215</u></p>					
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u></p>		<p><b>24B. DATE</b> <u>1-11-72</u></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>TZEMECH ZEDEK</u></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 13 1972</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>Paul E. Levinson</u></p>		<p><b>25C. FUNERAL DIRECTOR</b> ADDRESS <u>SOI. LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u></p>	

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ALISON, ELEANOR, JR. JAMES

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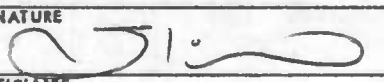
ALISON, ELEANOR, JR. JAMES

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ALISON, ELEANOR, JR. JAMES

# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>C-552</span> <span>72 00353</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 72 00353</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>CUMMINGS, EVA</b>		2. DATE AND HOUR OF DEATH <b>11/9/72 9-15 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL - BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>7500 LISBURN ROAD #21208</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/95</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	9. AGE (In years last birthday) <b>76</b>
11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ISRAEL ROSENBLUM</b>		14. MOTHER'S MAIDEN NAME <b>LEAH ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-66-7107</b>	
17. INFORMANT <b>MRS. MORRIS ZISKIND, 7 STONEHENGE CIRCLE, APT. 3</b>		ADDRESS	
18. <b>184.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CARCINOMA of VULVA - EXTENSIVE CARCINOMATOSIS</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Abdominal VISCERA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>INTESTINAL OBSTRUCTION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>11/8/72</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LAPAROTOMY ENTERO-ENTERO-COLIC ANASTOMOSIS</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCURRED</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>11/9/72</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR		(If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <b>11/8/72</b> 19 to <b>11/9/72</b> 19 that (I) (we) last saw the deceased alive on <b>11/9/72</b> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>11/9/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>		23D. ADDRESS <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-11-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>		25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	

THE UNITED STATES

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

ADJUTANT GENERAL'S OFFICE

1911

THE ADJUTANT GENERAL'S OFFICE, WASHINGTON, D. C.

THE ADJUTANT GENERAL'S OFFICE, WASHINGTON, D. C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00354	
G-650 72 00354					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Norman V. Greene</u>			2. DATE AND HOUR OF DEATH <u>1/9/72</u> <u>2:15</u> <u>am</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2740</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3118 BANCROFT ROAD, APT. A</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1904</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GENERAL STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ABRAHAM GREENE</u>		
14. MOTHER'S MAIDEN NAME <u>RACHAEL</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>218-32-0627</u>			17. INFORMANT <u>MRS. SELMA GREENE, 3118 BANCROFT RD., APT. A #15</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Heart Failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Ht Dis</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Heart Disease</u>		
(C) <u>Aortic Valve Insufficiency</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>1/9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/7</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sol Smith</u>				23B. DATE SIGNED <u>1/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sol Smith M.D.</u>				23D. ADDRESS <u>6810 Park Heights Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-11-72</u>		24C. NAME of CEMETERY or CREMATORY <u>AITZ CHAIM</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>SOC LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

10

THE NATIONAL BUREAU OF STANDARDS

1-1-1914

DEPARTMENT OF COMMERCE

WASHINGTON

GENERAL INVESTIGATION

RESEARCH DIVISION

UNIT

1-1-1914

THE NATIONAL BUREAU OF STANDARDS

RESEARCH DIVISION

WASHINGTON

1-1-1914

RESEARCH DIVISION

WASHINGTON

THE NATIONAL BUREAU OF STANDARDS



S-160

72 00355

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00355

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Arthur K. Schaeffer Schaeffer</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>10</b> Year <b>72</b> Hour <b>3:36 P.M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>19 N. Holliday Street</b>				3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>10</b> Year <b>72</b> Hour <b>3:36 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>May 8, 1917</b>				10. AGE (In years last birthday) <b>54</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joseph A. Schaeffer</b>		14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>401</b>	
15. MOTHER'S MAIDEN NAME <b>HARIE KIDG</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>125-03-4885</b>	
18. INFORMANT <b>Edward Pierson</b>				19. ADDRESS <b>10 Light Street</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>SEAMAN - OFFICER Merchant MARINE</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ANTecedent CAUSES</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				(A) IMMEDIATE CAUSE <b>Fatty alteration of liver</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>DUE TO, OR AS A CONSEQUENCE OF:</b> (C) <b>DUE TO, OR AS A CONSEQUENCE OF:</b>			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner H. Spitz, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner H. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>1-11-72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				21. AUTOPSY? (Yes or No) <b>Yes</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>1-14-72</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Prospect Hill Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Towson Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc.</b>				25D. ADDRESS <b>Towson, Md.</b>			

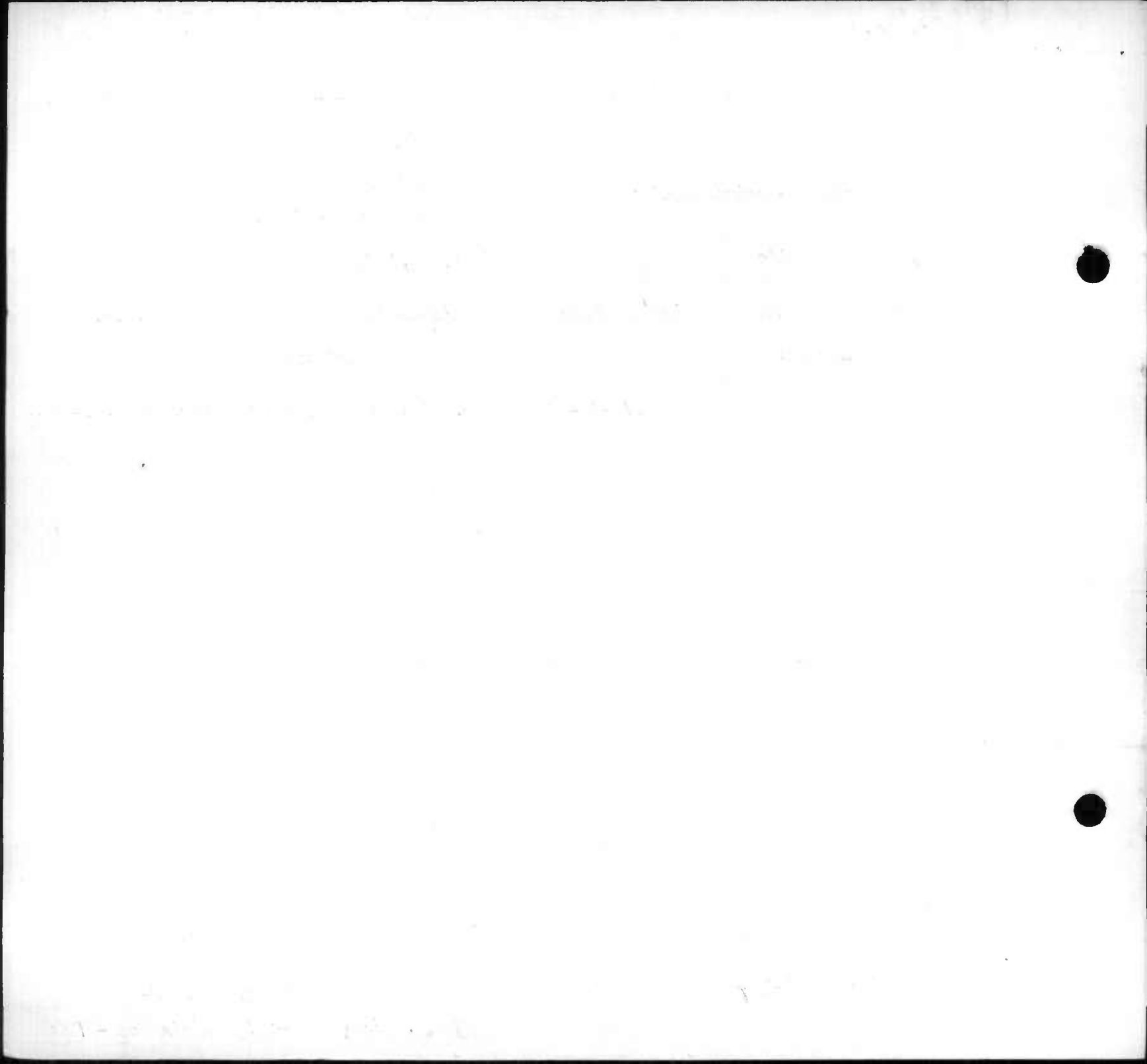
1-13-1972 - Letter from - Office of the Chief Medical Examiner, Werner U. Spitz, M.D.  
Deputy Chief Medical Examiner

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

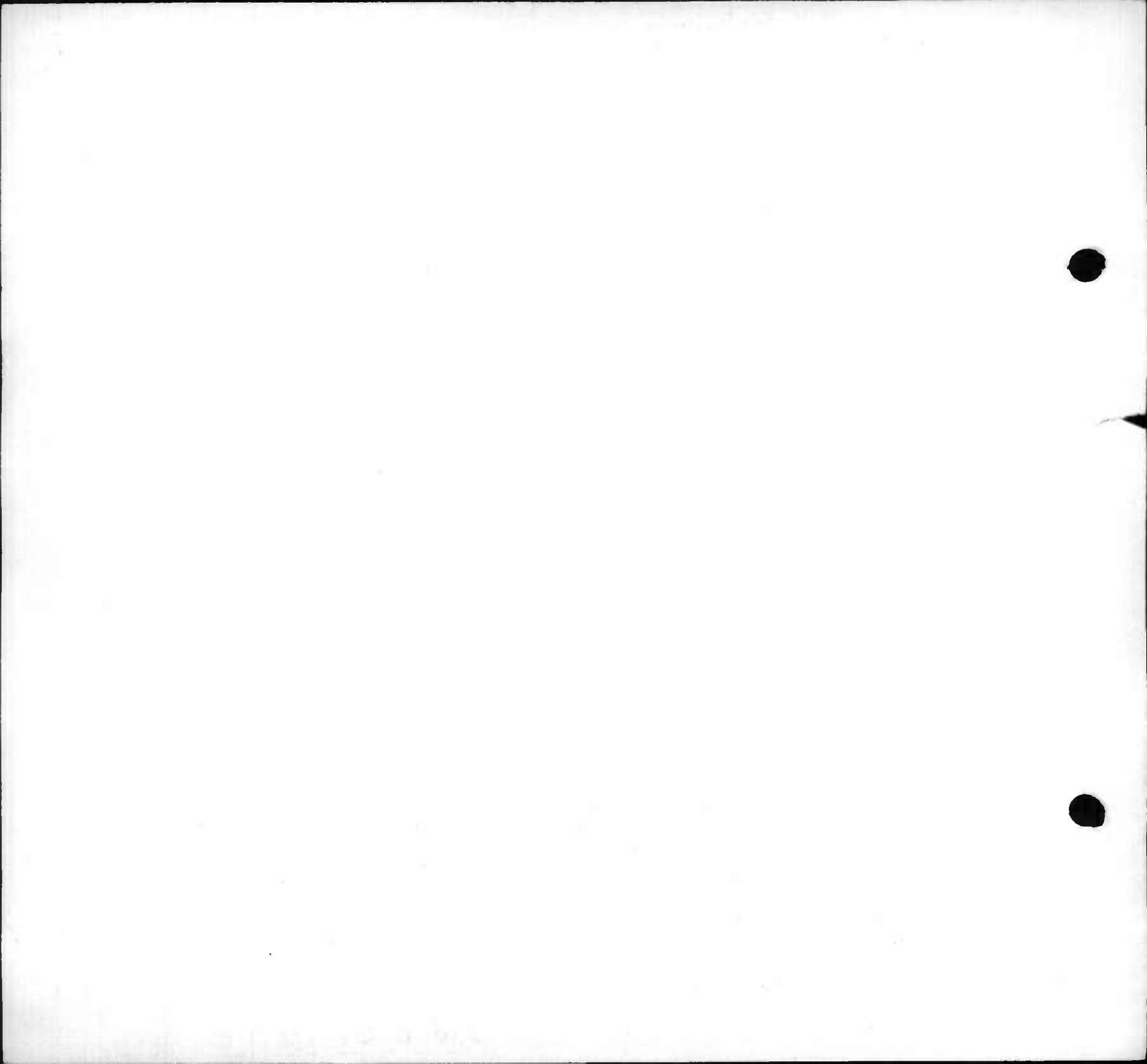
BALTIMORE CITY HEALTH DEPARTMENT				72 00356		REG. NO. 72 00356	
G-360				72 00356		72 00356	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Stanley Gaither		1-8-72 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland		2741	
44 Union Memorial Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3900 Southern Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
Male	White		Mar, 22, 1906	65			U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Route Salesman			Rice's Bakery		Lithuania		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes				214-18-7476		Mr. William Xander- 3900 Southern Ave.-21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Hemorrhage - Esophageal			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				metastatic bronchogenic carcinoma			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				2-3 hrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1/5 1972 to 1/8 1972 that (I) (we) last saw the deceased alive on 1/5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. BLATT, M.D.				1/10/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				Essex med. Center		Essex, Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-12-72		Druid Ridge Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 13 1972		John E. Miller, M.D.		John E. Miller Inc		6415 Belair Road-21206	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-200 72 00357		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00357
1. NAME OF DECEASED (Type or Print) <u>Lindley S. Nock</u>		2. DATE AND HOUR OF DEATH <u>8:10 Am 1/10/72</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Balt.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1629 Rickenbacker Rd.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/79</u>	9. AGE (In years last birthday) <u>92</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <u>437.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic cerebral vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> 19 <u>72</u> to <u>1/10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael A. Silverman MD</u>		23B. DATE SIGNED <u>1/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael A. Silverman MD</u>
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>1-11-72</u>		24C. NAME OF CEMETERY or CREMATORY
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>



B-000

72 00358

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00358

BIRTH NO.

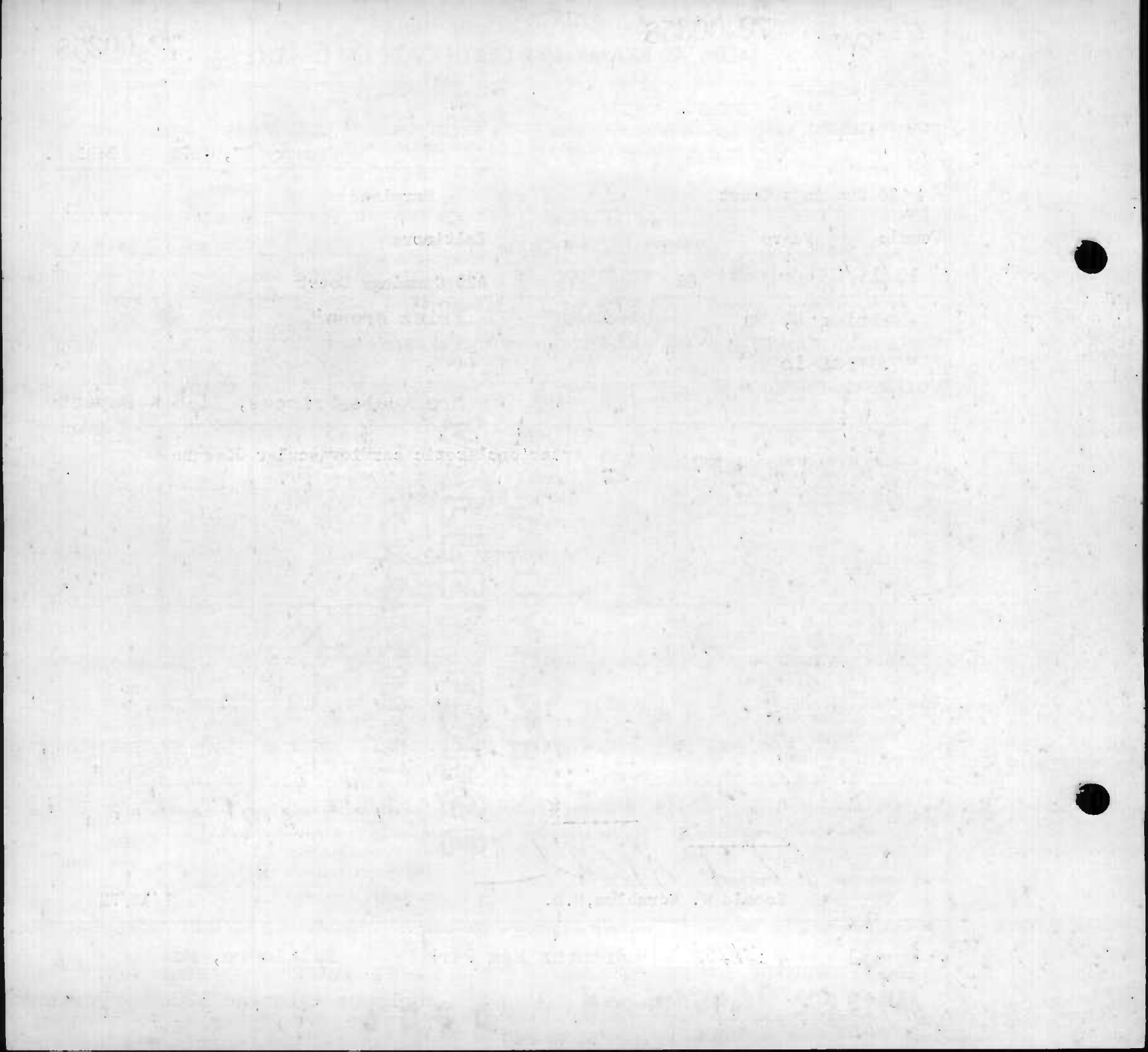
REG. NO.

1. NAME OF DECEASED (Type or Print) <b>LENA BEATRICE BOWIE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>68420 Cummings Court</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 12, 1972</b> 3:33 A.M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1702</b>	
9. DATE OF BIRTH <b>11/15/05</b>		10. AGE (In years last birthday) <b>66</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF U.S. OR FOREIGN COUNTRY?	
13. FATHER'S NAME <b>Fritz Brown</b>		14. STREET AND NUMBER <b>420 Cummings Court</b>	
15. MOTHER'S MAIDEN NAME <b>Lena</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs Adele Briscoe, 2138 W Fayette</b>	

19. <b>4/2.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

20A. DATE OF OPERATION <b>1/15/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Normal causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED: <b>1/12/72</b> EXAMINER'S NAME (Type)					

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Av</b>	

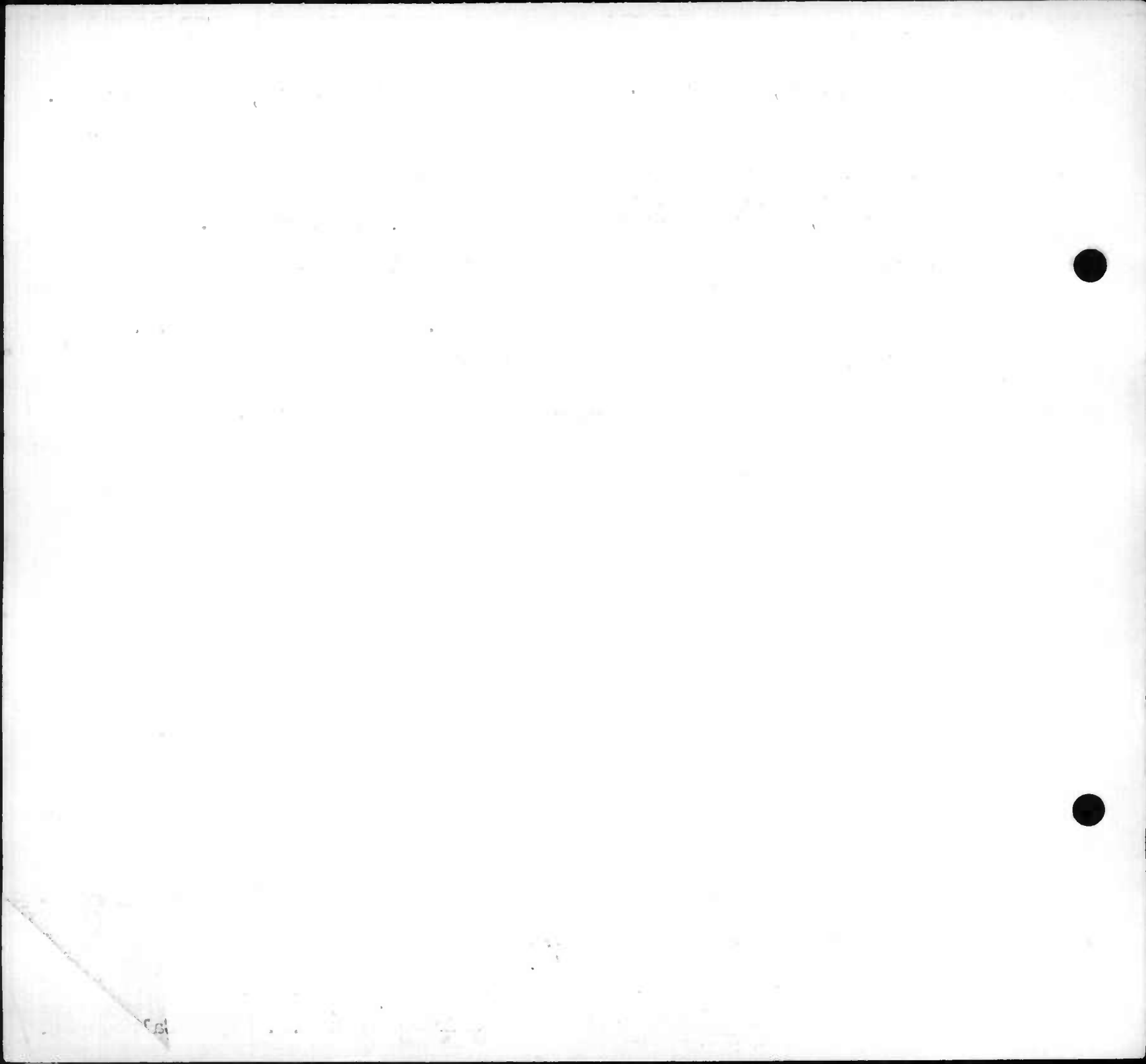




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-230 72 00359		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00359 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lockett, Bertha M.</b>		2. DATE AND HOUR OF DEATH <b>January 10, 1972 8:05 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1510</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Good Samaritan Hospital</b> <b>5601 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21239</b>		E. STREET AND NUMBER <b>4029 W. Coldspring La.</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09/08/11</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Murray</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Taylor</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-12-2988</b>		17. INFORMANT ADDRESS <b>Wm Murray same.</b>	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremic Conc</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus w/ renal disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2 0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11/22</b> 19 <b>71</b> to <b>1/10</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>1/10</b> 19 <b>72</b> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen B. Baylin</b>		M.D. <b>4.0</b> DEGREE		23B. DATE SIGNED <b>1/10/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stephen B. Baylin, M.D.</b>		23D. ADDRESS <b>Good Samaritan Hospital</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>		25C. FUNERAL DIRECTOR <b>W. Bailey</b> <b>W. Bailey</b> <b>1348 Galhoun St.</b>	



T-250

72 00360

BALTIMORE CITY HEALTH DEPARTMENT

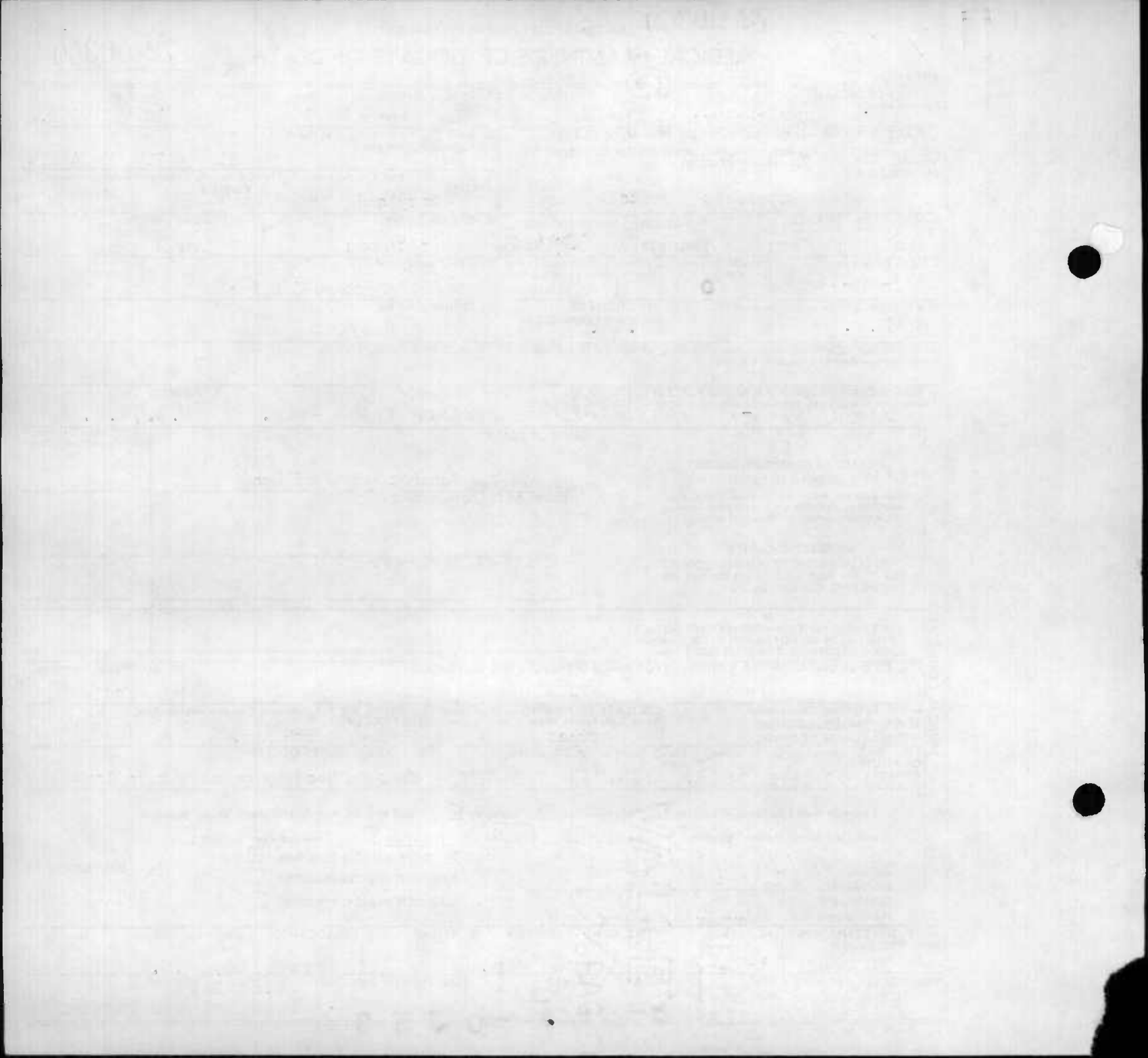
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00360

BIRTH NO.

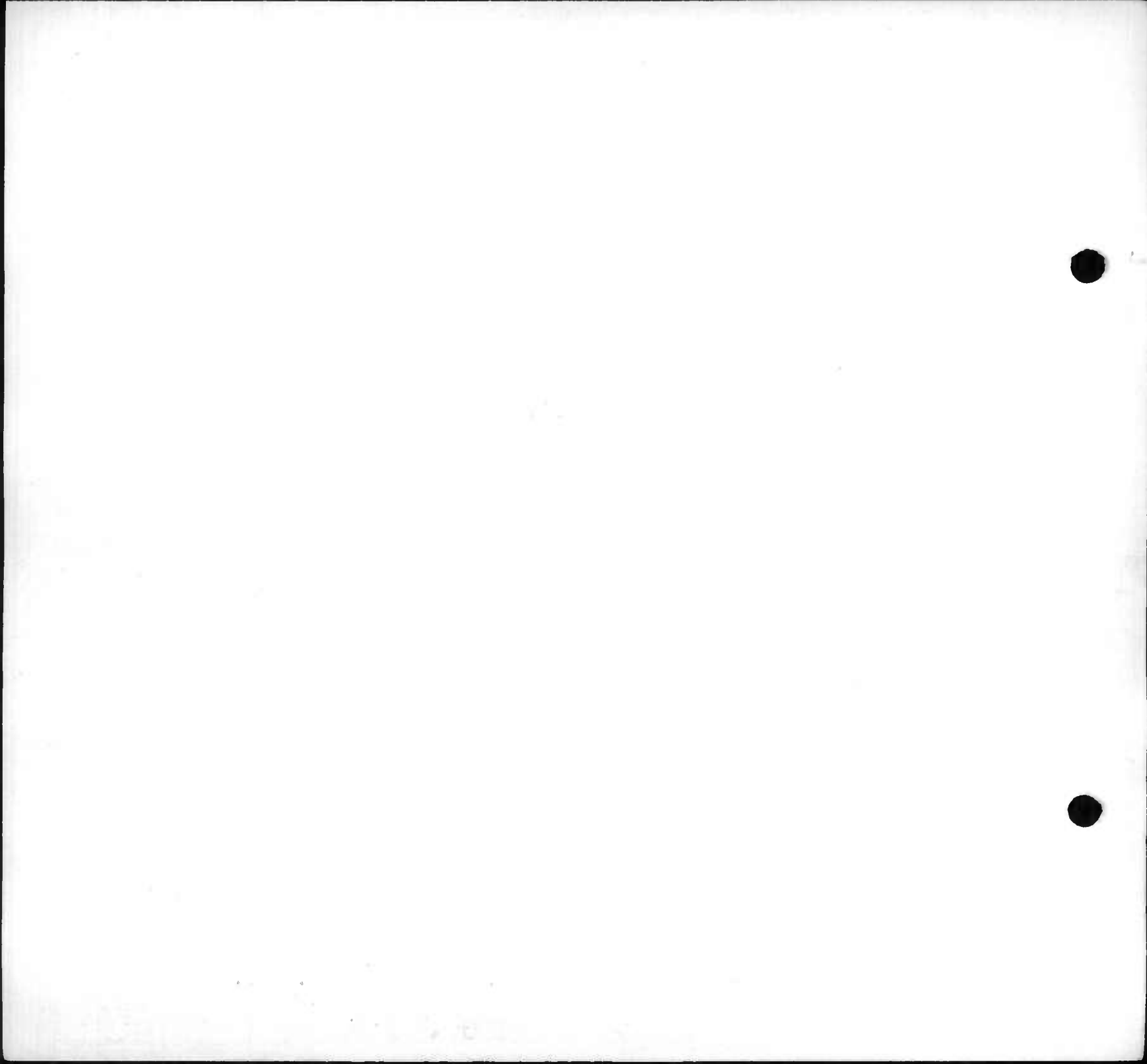
1. NAME OF DECEASED (Type or Print) Clinton Tyson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 11 72 2:04 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 11 72 2:04 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2739	
9. DATE OF BIRTH 3-10-11		10. AGE (in years lost birthday) 60	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give year or date of service yes 7/30/42-11/8/45		17. SOCIAL SECURITY NO. 231071353	
18. INFORMANT Esther Tyson -sis.		ADDRESS N.Y., N.Y.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 1 11 72 A. 2:00 m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1200 W. North Ave.		22F. HOW DID INJURY OCCUR? Shot in head by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-11-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-14-72	
24C. NAME OF CEMETERY or CREMATORY Church Cem.		24D. LOCATION (City, town, or county) (State) Farmville, N.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR Kelson E.H.		ADDRESS 1348 Calhoun Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

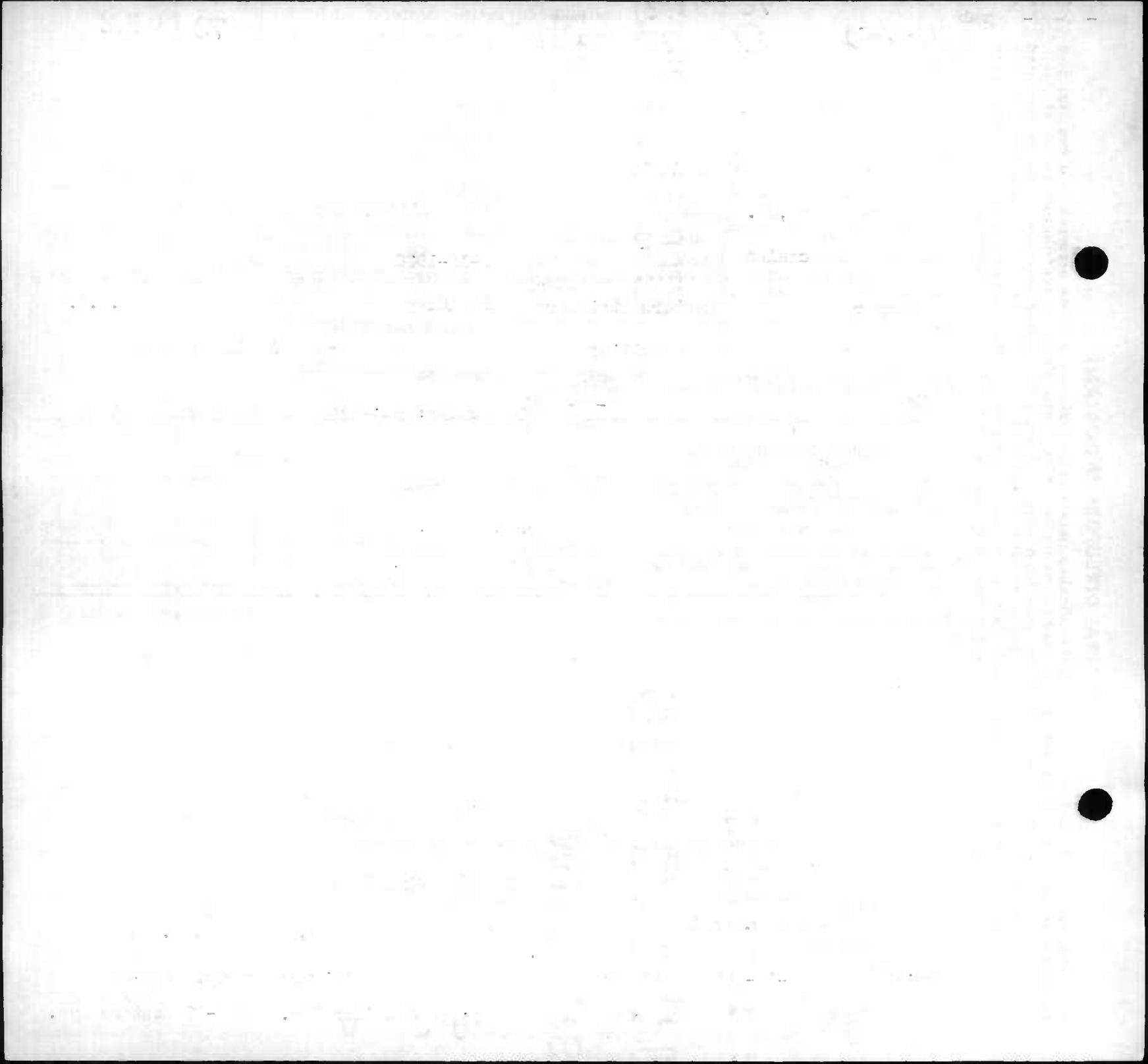
B-230				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00361	
BIRTH NO. 72 00361				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CLARA A Bost</u>				2. DATE AND HOUR OF DEATH <u>1/11/72</u> <u>8 30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GEN HOSP</u> <u>48</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1339 W. Mosher</u>							
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/17</u>	9. AGE (in years last birthday) <u>54</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXX Laundry</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk</u> <u>no</u>				16. SOCIAL SECURITY NO. <u>217222821</u>		17. INFORMANT <u>NETTIE Caldwell</u>	
18. <u>571.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>hepatic coma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
(B) <u>hepatic cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>UNKNOWN</u>				(C) <u>chronic alcoholism</u> <u>UNKNOWN</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>72</u> to <u>1/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael G. Faulkner MD</u>				23B. DATE SIGNED <u>1/11/72</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-14-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. J. 2000</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-452</b>		72-00362		CERTIFICATE OF DEATH		REG. NO. <b>72 00362</b>	
1. NAME OF DECEASED (Type or Print) <b>HEARL MULLINS</b> <b>Hearl Mullins</b>				2. DATE AND HOUR OF DEATH <b>1/10/72</b> <b>8<sup>05</sup>A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>4940 Eastern Ave</b> <b>Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>101</b>			
5. SEX <b>Male</b>				6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1-15-1928</b>				9. AGE (In years last birthday) <b>43</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stamper</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Eastern Stainless</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>George Mullins</b>			
14. MOTHER'S MAIDEN NAME <b>Virgie Vanover</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>403-30-9231</b>				17. INFORMANT <b>Records: BCH-4940 Eastern Avenue</b> ADDRESS <b>21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, atheria, etc. It means the disease, injury or complication which caused death.) <b>5/19/31</b> <b>CAUSE OF DEATH</b> <b>Cardiac Arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>COPD</b> (C) <b>AB A</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>3 days</b> <b>many years</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20. AUTOPSY? (Yes or No) <b>Yes</b>			
21A. DATE OF OPERATION <b>3/10/72</b>				21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Loss of Removal Pulsations</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/9/72</b> 19 <b>72</b> to <b>1/12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>James N. Engle, MD</b> DEGREE <b>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></b>			
23B. DATE SIGNED <b>1/12/72</b>				23C. PHYSICIAN'S NAME (Type) <b>James N. Engle</b>			
23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1-15-1972</b>				24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b> ADDRESS <b>1901-07 Eastern Ave.</b>	





72 00363

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 00363

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ALICE CRAVER

2. DATE AND HOUR OF DEATH

Jan 11. 72 2.30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital,  
4940 Eastern Avenue Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

224 420 E. 22nd Street 21218

5. SEX

Female

6. RACE

Negro

7. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

5-1-1900

9. AGE (In years last birthday)

71

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mitch Sparks

14. MOTHER'S MAIDEN NAME

Ella Moore

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) If yes, give war or dates of service

no

16. SOCIAL SECURITY NO.

17. INFORMANT Beatrice Craver

BCH RECORDS:

Isaac Craver

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

## CAUSE OF DEATH

Carcinoma of Stomach

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Severe emaciation

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

ASCVD, old TBC

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

One yr.

Several yrs

## MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 8-19 19 71 to 1-11-72 19 72

that (X) (we) last saw the deceased alive on Jan 11. 19 72 and that in (X) (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.

23A. SIGNATURE

M. Haghshehass. M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Jan. 11. 72

23C. PHYSICIAN'S NAME (Type)

M. HAGHSHEHASS

23D. ADDRESS

Balt. City Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

transit-burial

24B. DATE

1-18-72

24C. NAME OF CEMETERY OR CREMATORY

Union Memorial Park

24D. LOCATION

(City, town, or county)

Albany, Georgia

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1972

25B. NAME OF REGISTRAR

R. E. Jones, Jr.

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Channing (P. H. H. H.)

Black

Channing (P. H. H. H.)

Channing (P. H. H. H.)

Channing (P. H. H. H.)

Channing (P. H. H. H.)

Channing (P. H. H. H.)

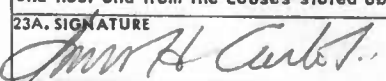
Channing (P. H. H. H.)

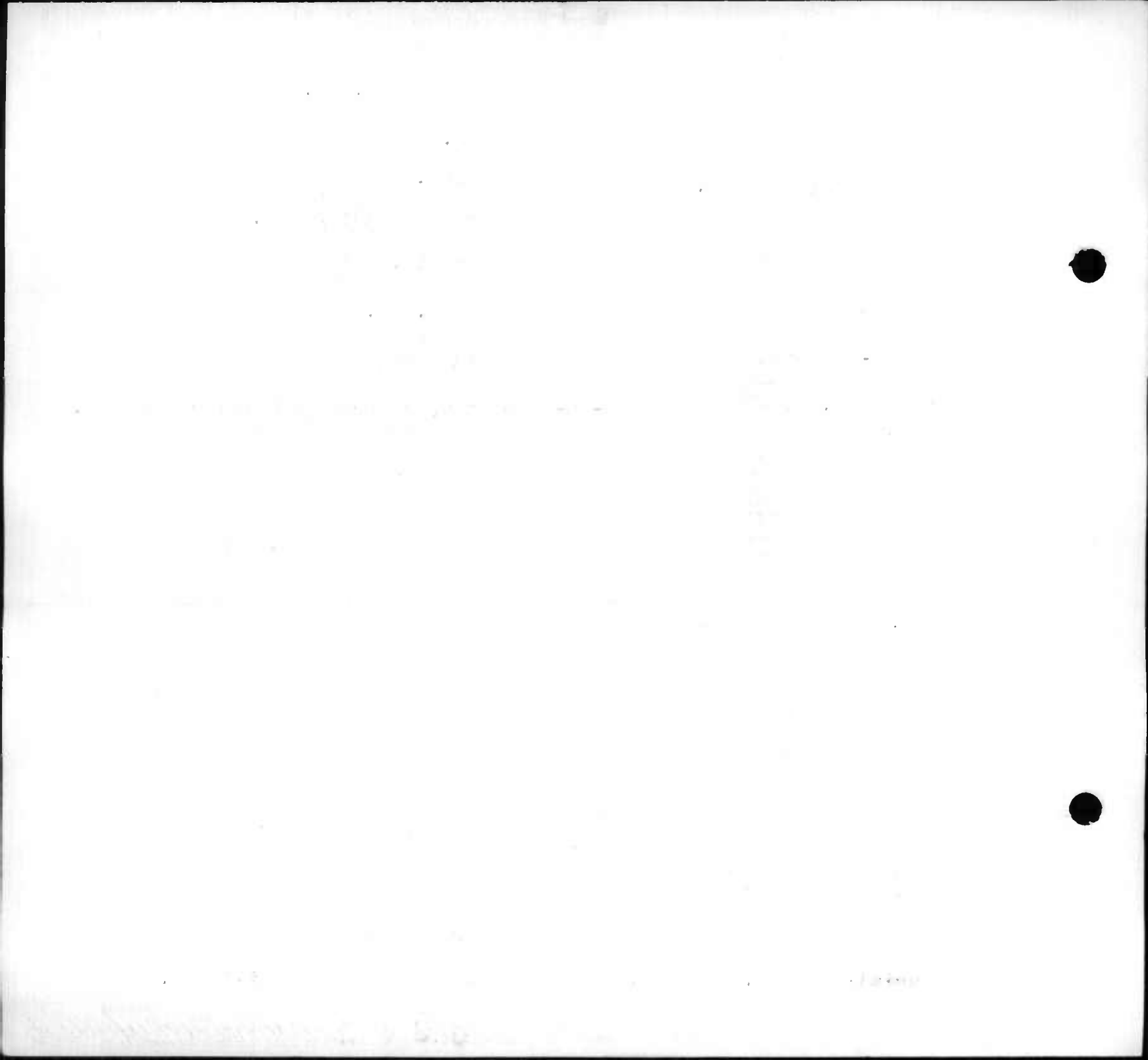
Channing (P. H. H. H.)

Channing (P. H. H. H.)

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00364</u>	
<b>BIRTH NO.</b> <u>L-220</u> <b>1. NAME OF DECEASED</b> (Type or Print) <b>HOWARD LUCAS</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>JAN. 11, 1972</b>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>3027 Spaulding Ave.</b> <u>00</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>Md.</b> <b>2717</b> <b>C. CITY OR TOWN</b> <b>Balto.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3027 Spaulding Ave.</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 13, 1902</b>	<b>9. AGE</b> (in years last birthday) <b>69</b>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Custodian</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto. Md.</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>13. FATHER'S NAME</b> <b>Augustus Lucas</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Nancy Posey</b>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. I</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>217-09-5470</b>			<b>17. INFORMANT</b> <b>Mildred Lucas</b>			<b>ADDRESS</b> <b>3027 Spaulding Ave.</b>	
<b>18. CAUSE OF DEATH</b>							
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>(A) IMMEDIATE CAUSE</b> <b>Due to, or as a consequence of:</b> <b>Carcinoma of the lung - 6-8 yrs</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>6-8 yrs</b>	
<b>(B) Anterior wide spread</b> <b>Due to, or as a consequence of:</b>				<b>(C)</b>			
<b>II</b>							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>							
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>none</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>no</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>(APPROX.)</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 1971</u> <b>to</b> <u>Jan 11, 1972</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 7, 1972</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> <b>13 Jan 72</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. H. Carl</b>				<b>23D. ADDRESS</b> <b>4432 Neil Hwy Ch</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>Jan. 15/72</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Mt. Calvary Cem.</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Ceder Hill Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 13 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Salsbery</b>		<b>25C. FUNERAL DIRECTOR</b> <b>William J. General</b>		<b>ADDRESS</b> <b>319 N. Howard St</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>72 00365</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>72 00365</u>	
1. NAME OF DECEASED (Type or Print) <u>JOHN D. HAINEY (Haney)</u>			2. DATE AND HOUR OF DEATH <u>JAN. 12, 1972</u> <u>2 30</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>1509</u>		
C. CITY OR TOWN <u>BALTIMORE</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>2140 MT. HOLLY ST.</u>					
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/21</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL ERECTOR</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TENN. Memphis</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ebner H. Haney</u>		14. MOTHER'S MAIDEN NAME <u>Annie Haney</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>252-24-9536</u>		17. INFORMANT <u>Mrs. Eleanor Haney</u> ADDRESS <u>2140 Mt Holly St.</u>	
18. <u>421.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ACUTELY DAMAGED AORTIC VALVE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ACUTE BACTERIAL ENDOCARDITIS of</u> <u>mitral &amp; aortic valves</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>JAN 12, (10 AM)</u> 19 <u>72</u> to <u>JAN. 12 (2 30 PM)</u> 19 <u>72</u> and that (1) (we) last saw the deceased alive on <u>JAN. 12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard H. Balcer M.D.</u>			23B. DATE SIGNED <u>1/12/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>RICHARD H. BALCER M.D.</u>			23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-15-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk. Balto Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Balcer, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Robert E. Balcer, Jr.</u>		25D. ADDRESS <u>1701-18th St.</u>			

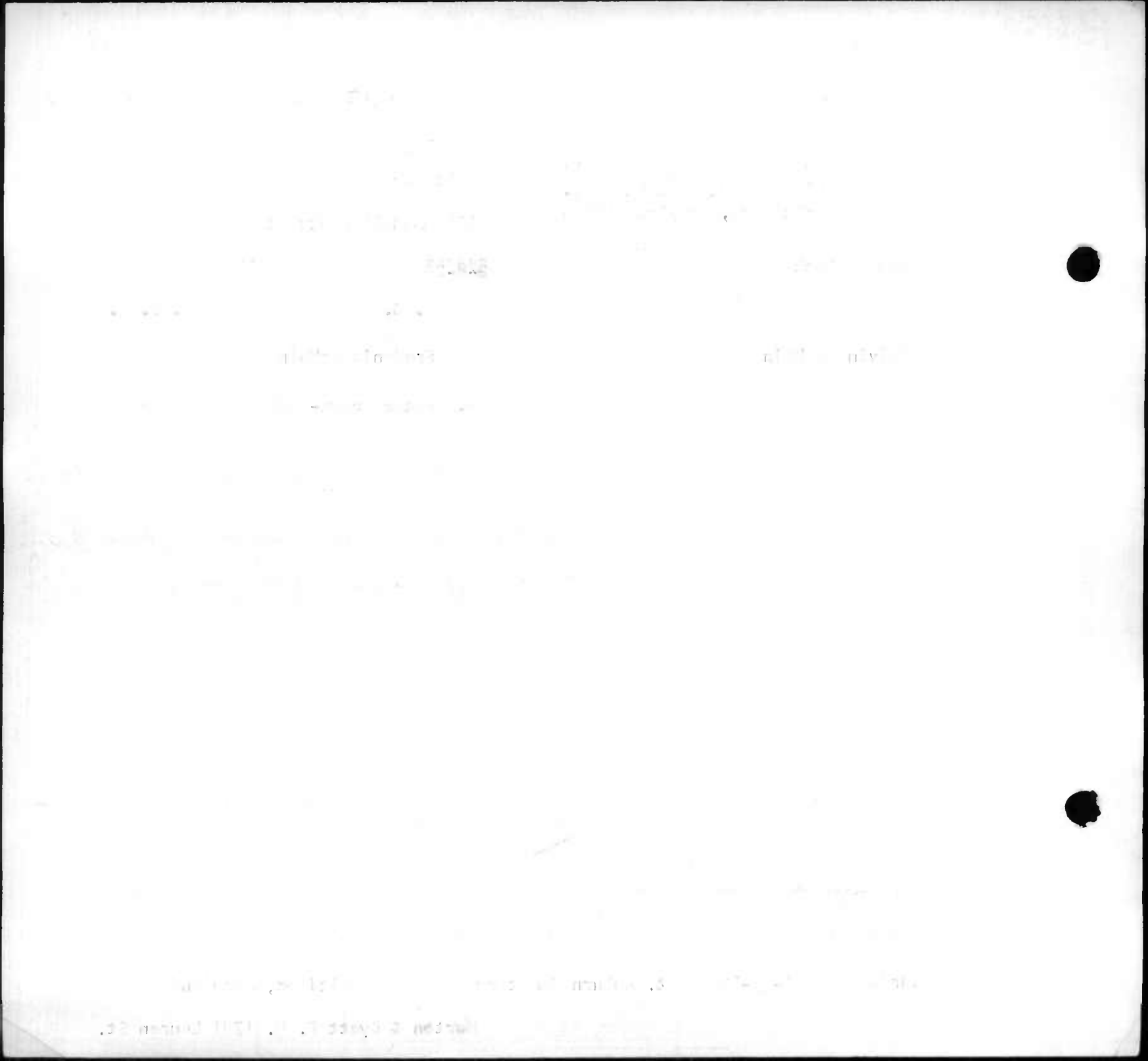
1-18-1972 - Correction Form from Funeral Director

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00366</u>		
BIRTH NO. <u>72 00366</u>		1. NAME OF DECEASED (Type or Print) <u>BROWN. GALISHA.</u>		2. DATE AND HOUR OF DEATH <u>1/10/72</u> <u>1:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital Complexx</u> <u>2600 Liberty Heights Ave.</u> <u>Baltimore, Maryland 21215</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1303</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2519 McCulloh Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-20</u>	9. AGE (In years last birthday) <u>51</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. C.</u>		
13. FATHER'S NAME <u>Calvin Mc Wain</u>			14. MOTHER'S MAIDEN NAME <u>Fredonia McWain</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Baxter Brown-Husband</u> ADDRESS <u>Same</u>		
18. <u>481 x I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>2° to GRAV - ve Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Right Upper Lobe Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>nine day</u> <u>nine day</u>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>1/9</u> 19 <u>72</u> to <u>1/10</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>1/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.				
23A. SIGNATURE <u>Rayman I. Alley M.D.</u>			23B. DATE SIGNED <u>1/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>RAYMAN. I. Alley M.D.</u>	
23D. ADDRESS <u>PROVIDENT HOSP. BALT. M.D.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				
24B. DATE <u>1-15-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F. H.</u>		
25D. ADDRESS <u>1701 Lauren St.</u>						

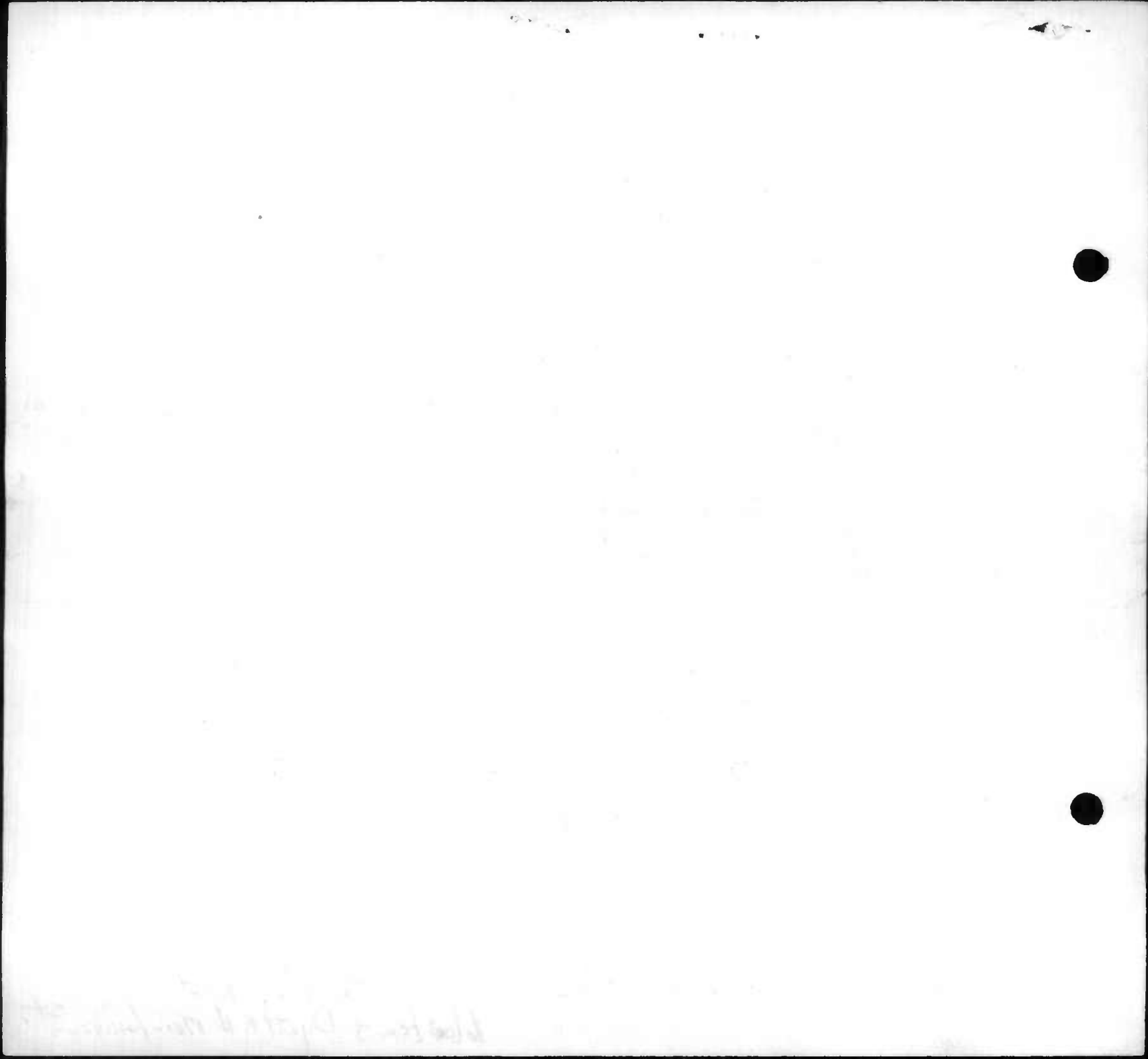




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00367	
CERTIFICATE OF DEATH					
BIRTH NO. 72-00148		2. DATE AND HOUR OF DEATH 5:40 Jan. 12 - 1972			
1. NAME OF DECEASED (Type or Print) Johnson Shannon (Sharon)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hosp. 3001 South Hanover St. Baltimore, Md. 21230		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY U.S.A. 2543			
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-20-70		9. AGE (In years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Johnson	
14. MOTHER'S MAIDEN NAME Mary Basnight		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joyce Smith (Aunt)		ADDRESS 1101-Alexander St. Apt 11A		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)	
19. CAUSE OF DEATH		A) IMMEDIATE CAUSE Status Epilepticus		DUE TO, OR AS A CONSEQUENCE OF:	
B) Pneumonia, Bilateral		DUE TO, OR AS A CONSEQUENCE OF:		C)	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)		21. ANTECEDENT CAUSES		22. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
23. MEDICAL CERTIFICATION		24. DATE OF OPERATION 1-15-72		25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2635 Kent St. Balt. Md. 21230	
29. TIME OF INJURY (APPROX.) Jan. 1 1972		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		31. HOW DID INJURY OCCUR? By herself None No Injuries	
32. I certify that (I) (this hospital) attended the deceased from 1/8/72 to 1/12/72 that (I) (we) lost saw the deceased alive on 1/12/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		33. SIGNATURE Duck Kee Lee M.D. DEGREE		34. DATE SIGNED Jan. 12 1972	
35. PHYSICIAN'S NAME (Type) Duck Kee Lee M.D. DEGREE		36. ADDRESS 3001 South Hanover St. Balt. Md. 21230		37. NAME OF CEMETERY or CREMATORY Mt. Auburn	
38. BURIAL CREMATION, REMOVAL (Specify) Burial		39. DATE 1-15-72		40. LOCATION (City, town, or county) (State) Ba Ht, Md	
41. DATE REC'D BY HEALTH DEPT. JAN 13 1972		42. NAME OF REGISTRAR R. E. F. Taber, Jr.		43. FUNERAL DIRECTOR Dyett F. H. 1701-Hanovers St.	



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## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EFFIE M. WILLIAMS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>1603 Hilton Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 12, 1972</b> Hour <b>8:25 A.</b> M.	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>4-19-29</b>		10. AGE (In years last birthday) <b>42</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>U. S. A.</b>	E. STREET AND NUMBER <b>1603 Hilton Street</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <b>Hattie Rice</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>213-26-8815</b>	18. INFORMANT <b>Beverly Williams</b> ADDRESS <b>1603 N. Hilton St.</b>

MEDICAL CERTIFICATION	19. <b>E9801.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease- Overdose of Barbiturate</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:

20A. DATE OF OPERATION <b>0</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>no</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1603 Hilton Street</b>
22D. TIME OF INJURY (APPROX.) <b>1-12-72</b>	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? <b>Ingested barbiturate</b>

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type)		DATE SIGNED <b>1/12/72</b>	

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-15-72</b>	24C. NAME of CEMETERY or CREMATORY <b>B Mt. Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>	25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home</b>	ADDRESS <b>1701 L. urens St.</b>

1-17-72 - Form - Completion of cause of Death on a pending medical examiner death certificate. Ronald N. Kornblum, M.D.

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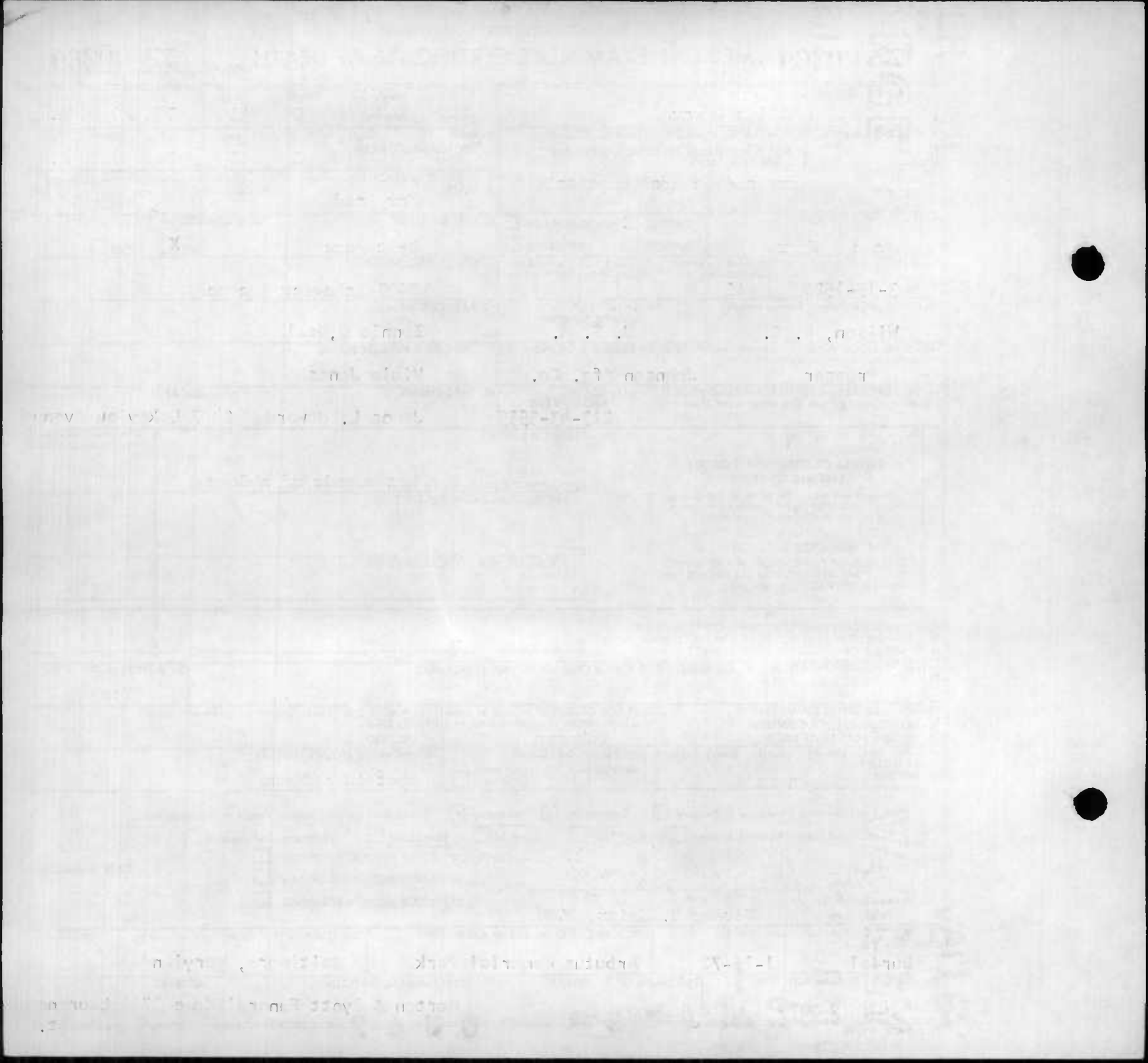
## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

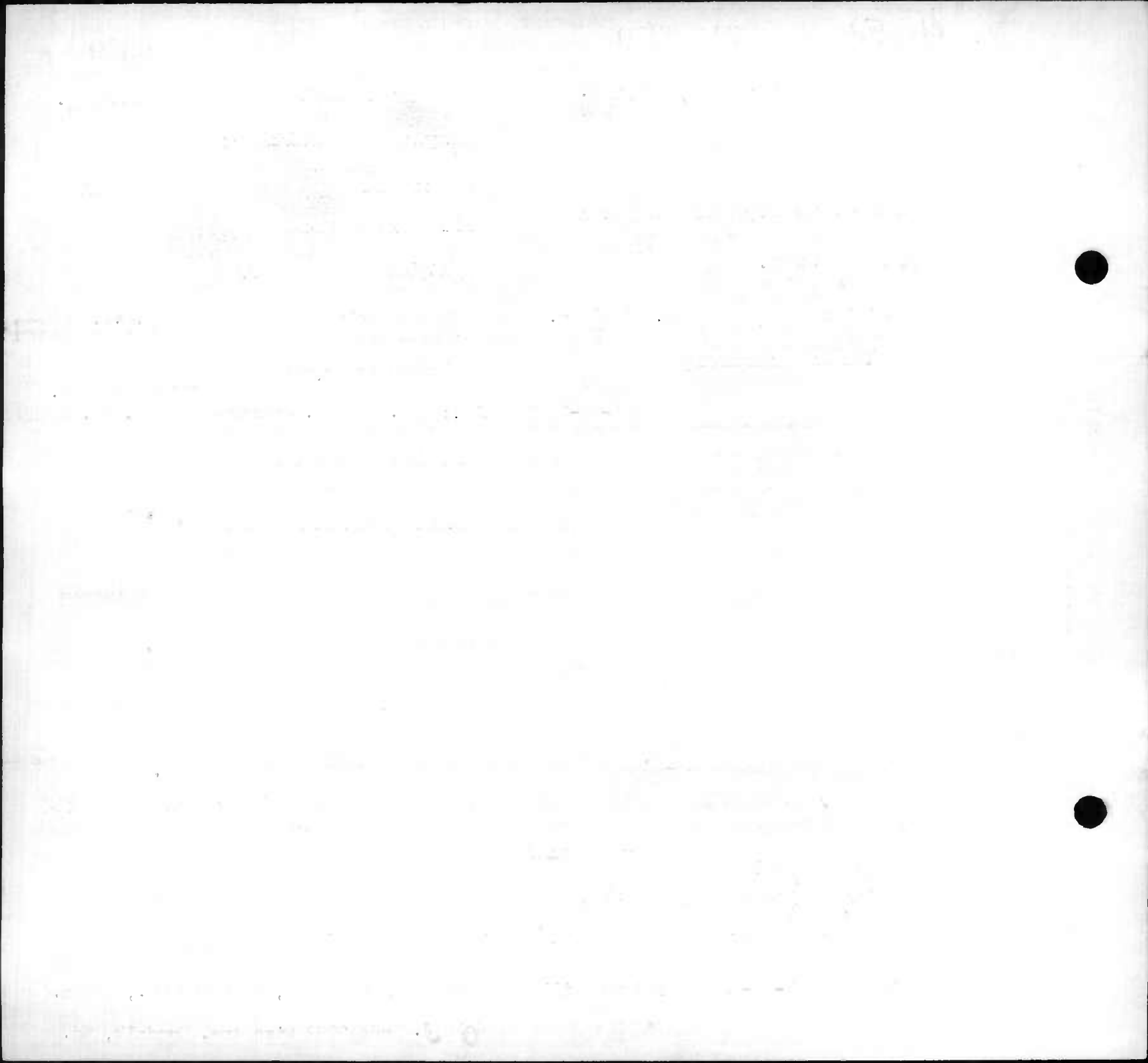
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillie Howard		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 11 72 4:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 48		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 11 72 4:20 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2407	
9. DATE OF BIRTH 3-15-1928		10. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Wilson, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		14B. KIND OF BUSINESS OR INDUSTRY Johnson Mfg. Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-43-3535	
18. INFORMANT James L. Howard		ADDRESS 2407 Lakeview Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Gunshot wounds of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22D. TIME OF INJURY (APPROX.) Unknown		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) unknown		22F. HOW DID INJURY OCCUR? shot in abdomen	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-11-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-15-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home		ADDRESS 1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-652		72 00370		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00370	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ARMSTRONG, Edgar S.</b>				2. DATE AND HOUR OF DEATH <b>1/11/72</b>   <b>1:50 p. m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Edgemere</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3310 Grace Road</b>					
5. SEX <b>Male</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/17/12</b>		9. AGE (In years last birthday) <b>59</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Armstrong</b>				14. MOTHER'S MAIDEN NAME <b>Helen Hartman</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>189-09-7851</b>		17. INFORMANT <b>Wife: Mrs. Sara M. Armstrong Balto. Md. 21219</b>			
18. <b>442X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiovascular Collapse</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Major Vessel Dissecting Aneurysm</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Bowel Necrosis</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>1-11</b> 19 <b>72</b> to <b>1-11</b> 19 <b>72</b> that <del>the</del> (we) last saw the deceased alive on <b>1-11</b> 19 <b>72</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>view</del> view the body after death.									
23A. SIGNATURE <b>Hugh Robinson M.D.</b>				23B. DATE SIGNED <b>1/11/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Hugh Robinson, M.D.</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodward Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Lancaster, Lancaster Co., Penna.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John J. Puda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			

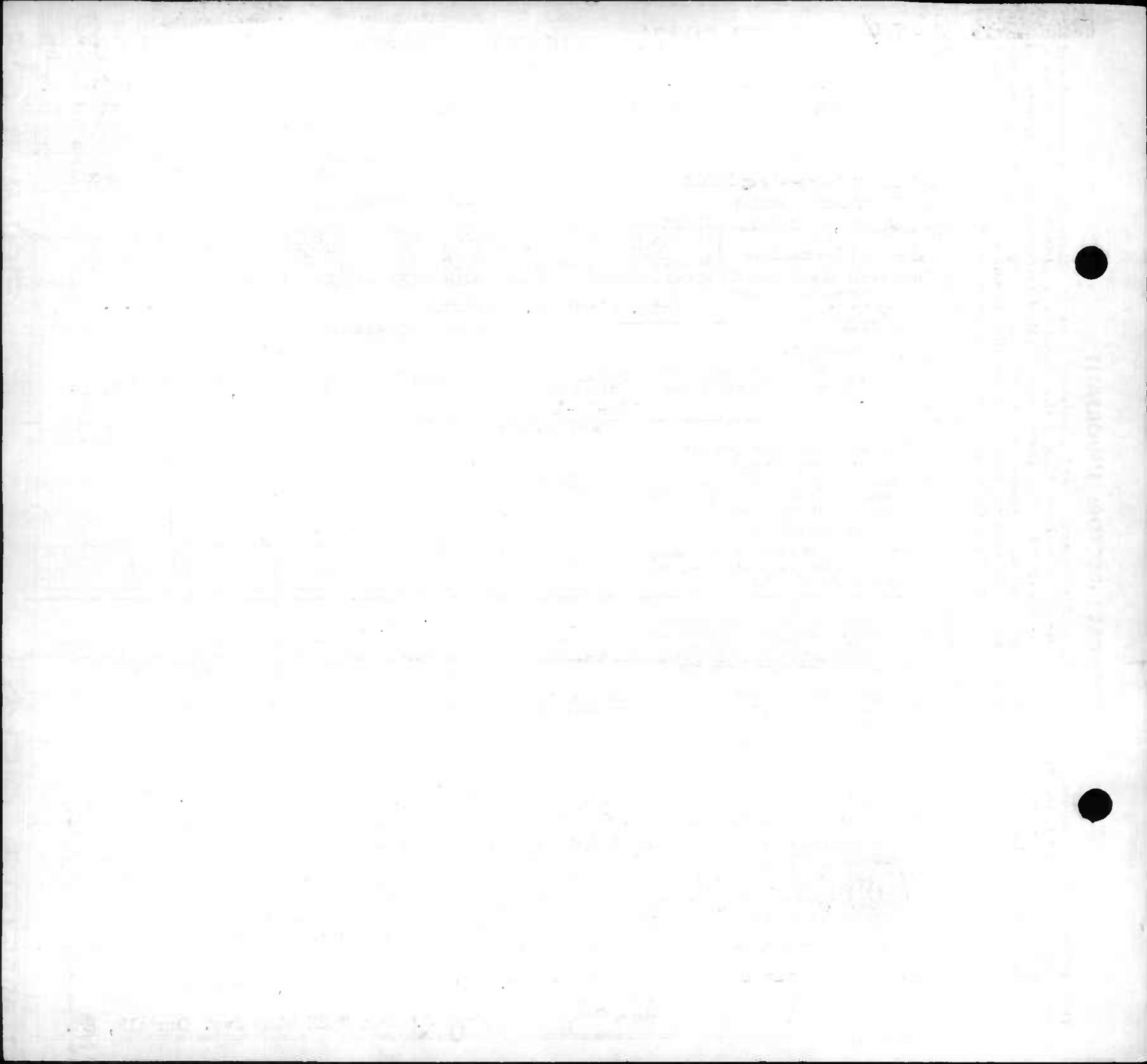




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-514 72 00371		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 00371	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Benefield, Joe A.		2. DATE AND HOUR OF DEATH 1/8/72 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300		C. CITY OR TOWN Dundalk Baltimore 21222 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/16/13		9. AGE (in years last birthday) 58		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Benefield		14. MOTHER'S MAIDEN NAME Josie Holland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-1289		17. INFORMANT 4940 Eastern Ave ADDRESS Baltimore, Maryland 21224 BCH - Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Pulmonary arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Metastatic adenocarcinoma of pancreas = Pulmonary metastases (C) Pneumothorax		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1/5/72 19 to 1/8/72 19 that (I) (we) last saw the deceased alive on 1/8/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ronald A. Griffin MD DEGREE	
23B. DATE SIGNED 1/8/72		23C. PHYSICIAN'S NAME (Type) Ronald A. Griffin		23D. ADDRESS Baltimore City Hosp 4940 Eastern Avenue 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-13-72		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park	
24D. LOCATION Dorsey, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 13 1972		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Dundalk, Md.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 00372				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00372	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Eleanora M. Brown</b>				2. DATE AND HOUR OF DEATH <b>January 8, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <b>Maryland</b>		B. COUNTY <b>2664</b>	
<b>00</b> 133 North Janney Street				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>133 North Janney Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1904</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Andrew J. Hall</b>				14. MOTHER'S MAIDEN NAME <b>Katie Harris</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-9641</b>		17. INFORMANT <b>Mr. Leroy K. Brown</b>		ADDRESS <b>Son: 1928 Dineen Drive Dundalk, Md. 21222</b>	
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiovascular Disease 1 1/2 yrs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/27</b> 19 <b>71</b> to <b>Present</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>10/4</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Donald H. Dembo</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Jan 11, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald H. Dembo, M.D.</b>				23D. ADDRESS <b>827 Linden Avenue Baltimore, Maryland 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/12/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			

Answered

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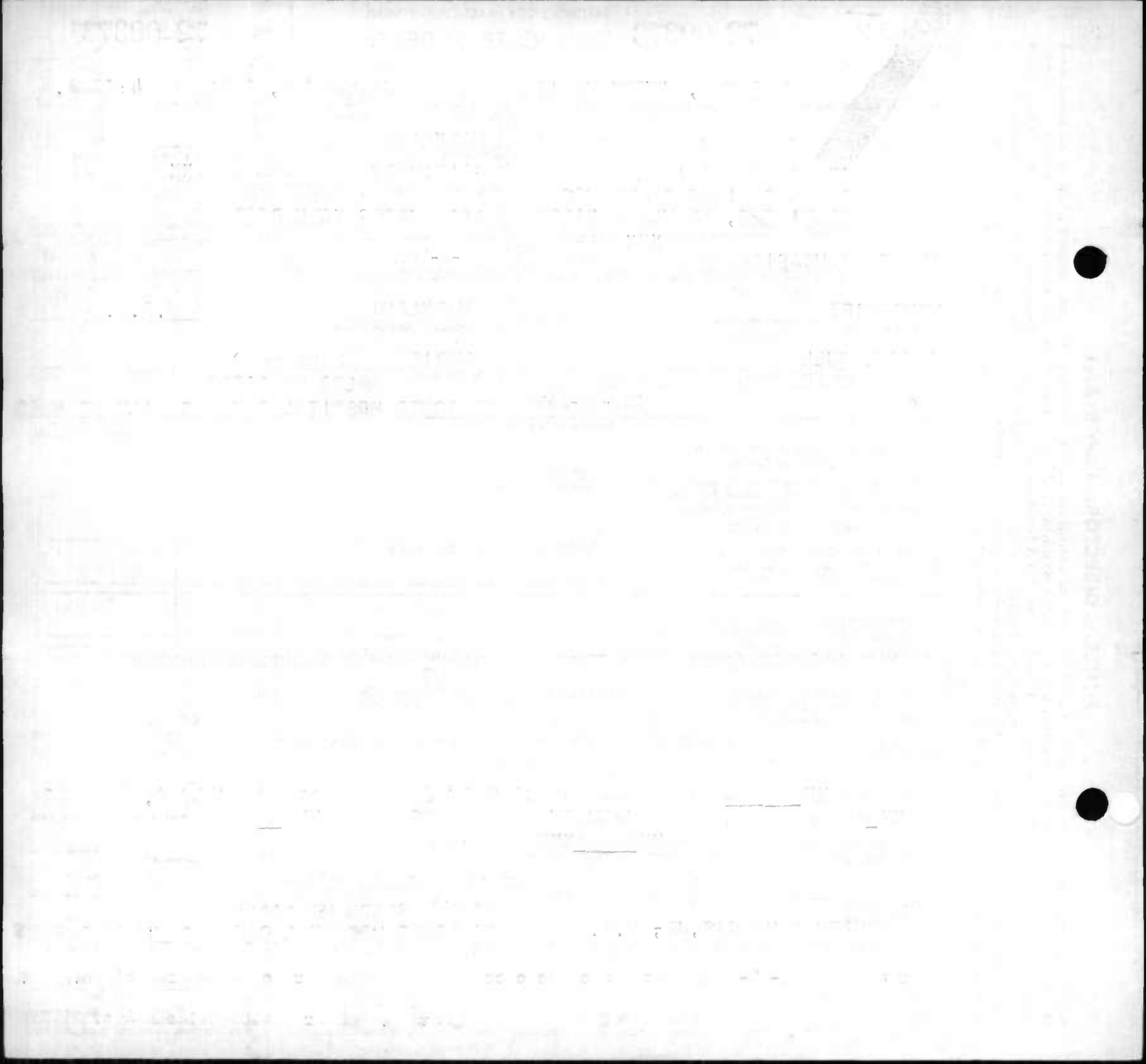
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00373	
BIRTH NO. 4-155		72 00373			
1. NAME OF DECEASED (Type or Print) HOFFMAN, BETTY MARIE			2. DATE AND HOUR OF DEATH JANUARY 9, 1972 4:37 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2582		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX FEMALE 6. RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3-3-1935 9. AGE (In years last birthday) 36		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SAMUEL BULL			14. MOTHER'S MAIDEN NAME MARIE (Unknown)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-30-5434		
17. INFORMANT BALTO MD 21229			ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES		
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Pneumonia		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II RHEUMATIC HEART DISEASE			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>XX</del> (this hospital) attended the deceased from JANUARY 6, 1972 to JANUARY 9, 1972 that <del>XX</del> (we) last saw the deceased alive on JANUARY 9, 1972 and that <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) (did) <del>XX</del> view the body after death.					
23A. SIGNATURE <i>Donato A. Vargas Jr</i>				23B. DATE SIGNED 1-9-72	
23C. PHYSICIAN'S NAME (Type) DONATO A VARGAS, JR., M.D.				23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-12-1972		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) Glen Burnie, Anne Arundel Co., Md.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-250		72 00374		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
<b>CERTIFICATE OF DEATH</b>				72 00374			
1. NAME OF DECEASED (Type or Print) <u>Disney, Mrs. Margaret</u>				2. DATE AND HOUR OF DEATH <u>1/10/72</u> <u>9:35 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2006</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>503 Parksley Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20-98</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>George Schmidt</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-48-3970</u>		17. INFORMANT <u>Mr. Vernon G. Disney, 534 Parksley Ave.</u> <u>PT'S CHART</u> <u>21223</u>		
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Cardiopulmonary insuff.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pos: Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>  <u>Congruent left leg -</u>			
19. DATE OF OPERATION <u>12-29-71</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GANGRENE @ LEG</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> <u>1971</u> to <u>1-10</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>9:35 P.M. 1-10 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ramiro Lindado</u>				23B. DATE SIGNED <u>1-10-72</u>		23C. PHYSICIAN'S NAME (Type) <u>RAMIRO LINDADO</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1-14-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>				25D. ADDRESS <u>4107 Wilkens Ave. 21229</u>			



~~SECRET~~

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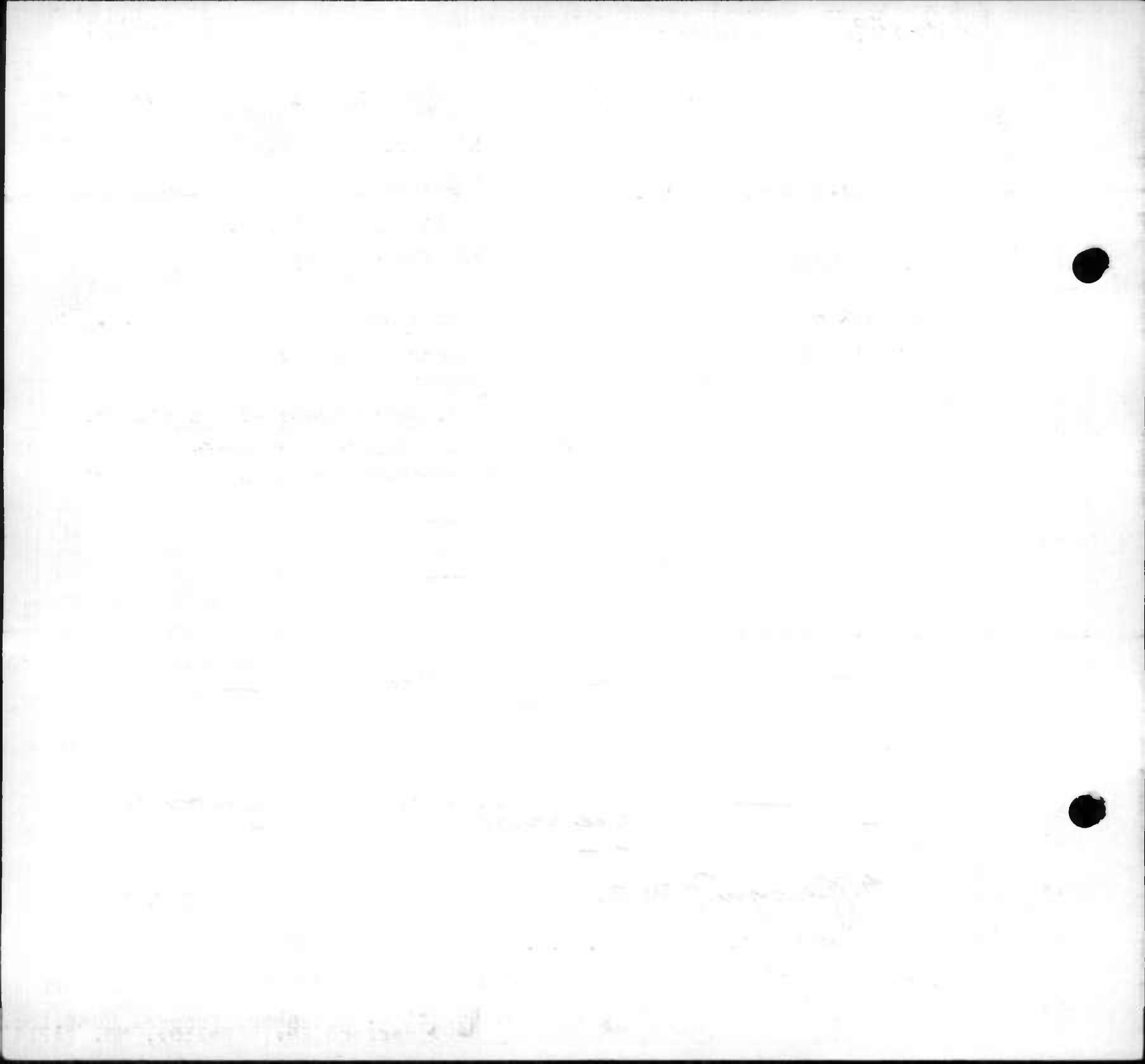




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-653		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00375	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ISABEL V. BRENT		1/8/72 10 <sup>30</sup> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2706	
00 6108 MARIETTA AVE.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6108 MARIETTA AVE.			
5. SEX F.	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1906	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Dominic Amarose		14. MOTHER'S MAIDEN NAME Gertrude Kremer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Betty Krebs -5 Farwell Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.4 I ARTERIO-SCLEROTIC C-V. DISEASE CORONARY FAILURE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH ARTERIO-SCLEROTIC C-V. DISEASE CORONARY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 9-71 19 to Dec 22-71 19 that (I) (we) last saw the deceased alive on Dec 22-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George J. Sawyer Jr. M.D.		23B. DATE SIGNED 1/8/72		23C. PHYSICIAN'S NAME (Type) GEORGE J. SAWYER JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/12/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1972		25B. NAME OF REGISTRAR Robert C. Altenburg		25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00376</u>	
<p><b>BIRTH NO.</b> <u>W-520</u></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <u>Anna May Wink</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <u>January 8, 1972</u> <u>6:30 P</u> M.</p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 The Wesley Home, Inc.</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2755</u></p> <p><b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <u>2211 West Rogers Avenue</u></p>			
<p><b>5. SEX</b> <u>F</u></p>	<p><b>6. RACE</b> <u>W</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <u>23 Jan. 1879</u></p>	<p><b>9. AGE</b> (In years last birthday) <u>92</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u></p>					
<p><b>13. FATHER'S NAME</b> <u>William Burkins</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Lydia Kohler</u></p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p><b>16. SOCIAL SECURITY NO.</b> <u>216 09 1906A</u></p>		<p><b>17. INFORMANT</b> <u>The Wesley Home, Inc.</u></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>412.4 I</u></p>		<p><b>CAUSE OF DEATH</b> <u>Ischemic heart disease</u></p>			
<p><b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>			
<p><b>II</b></p>					
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Cardiovascular insufficiency</u></p>					
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <u>No</u></p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>					
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>23 September 1968</u> to <u>5 January 1972</u>, that (I) (we) last saw the deceased alive on <u>3 January 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <u>John W. Barnaby</u></p>				<p><b>23B. DATE SIGNED</b> <u>11 Jan 72</u></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <u>Dr. John W. Barnaby</u></p>				<p><b>23D. ADDRESS</b> <u>1652 E. Belvedere Avenue, Baltimore, Md.</u></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>		<p><b>24B. DATE</b> <u>11 Jan. 72</u></p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Mt. Pleasant Cemetery</u></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <u>Stewartstown, Pennsylvania</u></p>					
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 13 1972</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>Walter J. Smith</u></p>		<p><b>25C. FUNERAL DIRECTOR</b> <u>Burgess Funeral Home</u></p>	
<p><b>ADDRESS</b> <u>Baltimore, Maryland</u></p>					

Adm. 21 yrs. 290.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00377	
BIRTH NO. 4-520 72 00377				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MARGARET V. HAINES</b>			2. DATE AND HOUR OF DEATH <b>1-8/72 3:53 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHN HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1306</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3513 CHESTNUT AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08/20/11</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Industrial Paper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>Atkinson, CHARLES W.</b>		
14. MOTHER'S MAIDEN NAME <b>HAINES, GRACE</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		
16. SOCIAL SECURITY NO. <b>212 03 2861</b>		17. INFORMANT <b>Albert H. Haines, Sr.</b> ADDRESS <b>Same</b>			
18. CAUSE OF DEATH <b>394.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INADEQUATE CARDIAC OUTPUT (SHOCK)</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) LONG STANDING CARDIAC DISEASE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>1-6/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MITRAL VALVE DISEASE</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 6 1972</b> to <b>JAN 8 1972</b> that (I) (we) last saw the deceased alive on <b>JAN 8 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. E. Eckhauser MD</b>				23B. DATE SIGNED <b>1-8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. E. ECKHAUSER</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITALS</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12 Jan 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b>	
24D. LOCATION <b>Carroll County, Maryland</b>		25A. DATE RECD BY HEALTH DEPT. <b>JAN 13 1972</b>			
25B. NAME OF REGISTRAR <b>Walter J. Hanco</b>		25C. FUNERAL DIRECTOR <b>Oursee Funeral Home, Baltimore, Md.</b>			

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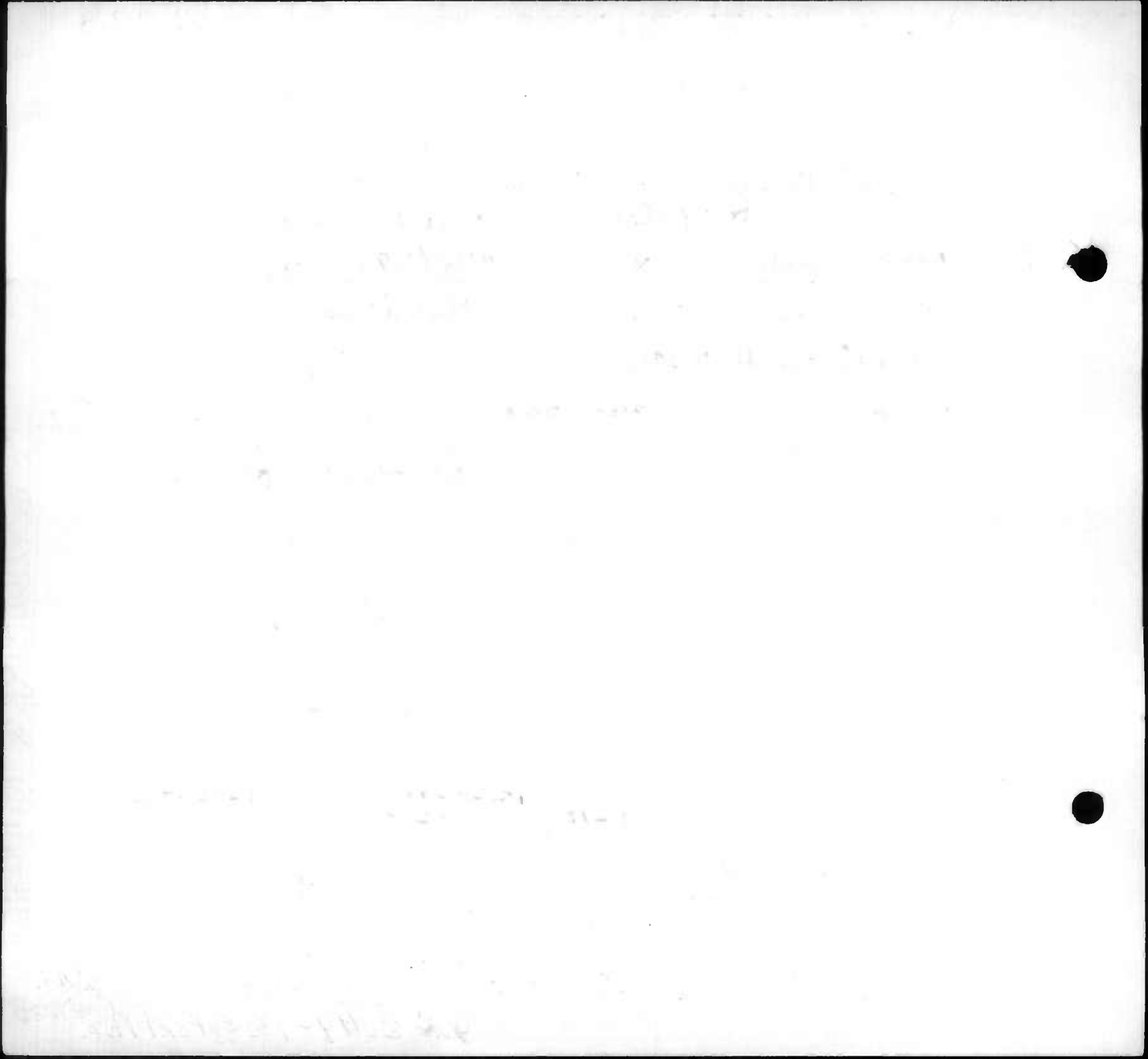
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 00378 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				72 00378 REG. NO.	
1. NAME OF DECEASED (Type or Print)		BROWN Agnes M.		2. DATE AND HOUR OF DEATH 1/10/72 at 7:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 43				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/18/1895		9. AGE (In years last birthday) 76		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Hirsch			
14. MOTHER'S MAIDEN NAME Hart		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO. 218-22-7189-B		17. INFORMANT Family - Spouse #4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) CAUSE OF DEATH 412.21 Respiratory failure may be consequence of stroke (b) due to P.V. Atherosclerosis & hypertension (c) and associated ASCVD.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-9-71 to 1-10-72 1972 that (I) (we) last saw the deceased alive on 1-10-72 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. Subbarao				23B. DATE SIGNED 1/10/72	
23C. PHYSICIAN'S NAME (Type) P. SUBBARAO				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-14-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Mt. Hope	
24D. LOCATION Baltimore		24E. CITY, town, or county Md.		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1972		25B. NAME OF REGISTRAR John E. Kelly		25C. FUNERAL DIRECTOR DR. Subbarao	
25D. ADDRESS 21230		25E. ADDRESS 21230			

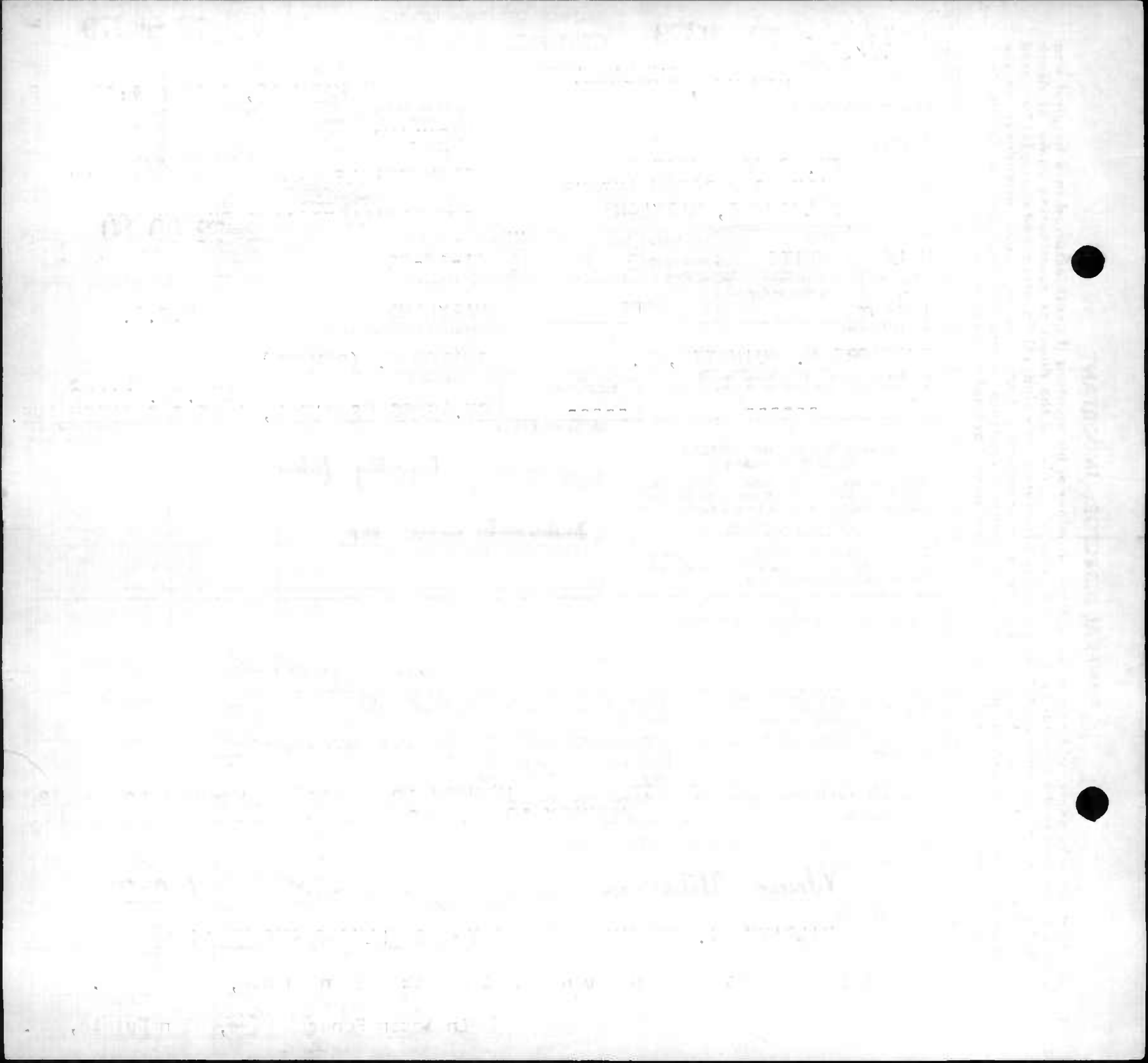




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00379	
0-530 72 00379 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>QUIMETTE, NELSON JOHN</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 10, 1972 7:37 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>40</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>CROWNSVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>SUMMERHILL TRAILER PK BOX 100</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-10-72</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>THEODORE N. QUIMETTE, JR.</b>			14. MOTHER'S MAIDEN NAME <b>SHARON E. (BOHNER)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT <b>BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>		
18. <b>5-5-1-13 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Diaphragmatic hernia, PDA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 10 1972</b> to <b>JANUARY 10 1972</b> that (I) (we) last saw the deceased alive on <b>JANUARY 10 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vilavun C. Thitivarana</b>			23B. DATE SIGNED <b>1-11-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>VILAVUN C. THITIVARANA</b>			23D. ADDRESS <b>CATON &amp; WILKENS AVENUE 21229</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/13/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, AA Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 13 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	25C. FUNERAL DIRECTOR <b>Sheldon Funeral Home, Glen Burnie, Md.</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Raymond Edward Stevens

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED

☒ NEVER MARRIED

WIDOWED

☐ DIVORCED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired- Iron Worker

13. FATHER'S NAME

Harry L. Stevens

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

213-09-4401A

17. INFORMANT

4940 Eastern Avenue  
BCH: Records Baltimore, Maryland 21224

18.

20501

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Gram Negative Sepsis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Upper G. I. Bleed.

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Acute Myelomonocytic Leukemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 week

2 days

6 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Probable Acute Diverticulitis.

1 week

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work

Not While At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 9/20/71 to 1/9/72 19 that (L) (we) last saw the deceased alive on 1/9/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William P. Hunt M.D.

DEGREE

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

Jan - 9, 1972

23C. PHYSICIAN'S NAME (Type)

William Hunt, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-12-72

24C. NAME of CEMETERY or CREMATORY

Reformed

24D. LOCATION (City, town, or county)

Knoxville md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 13 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Hatch Funeral Home Brunswick md

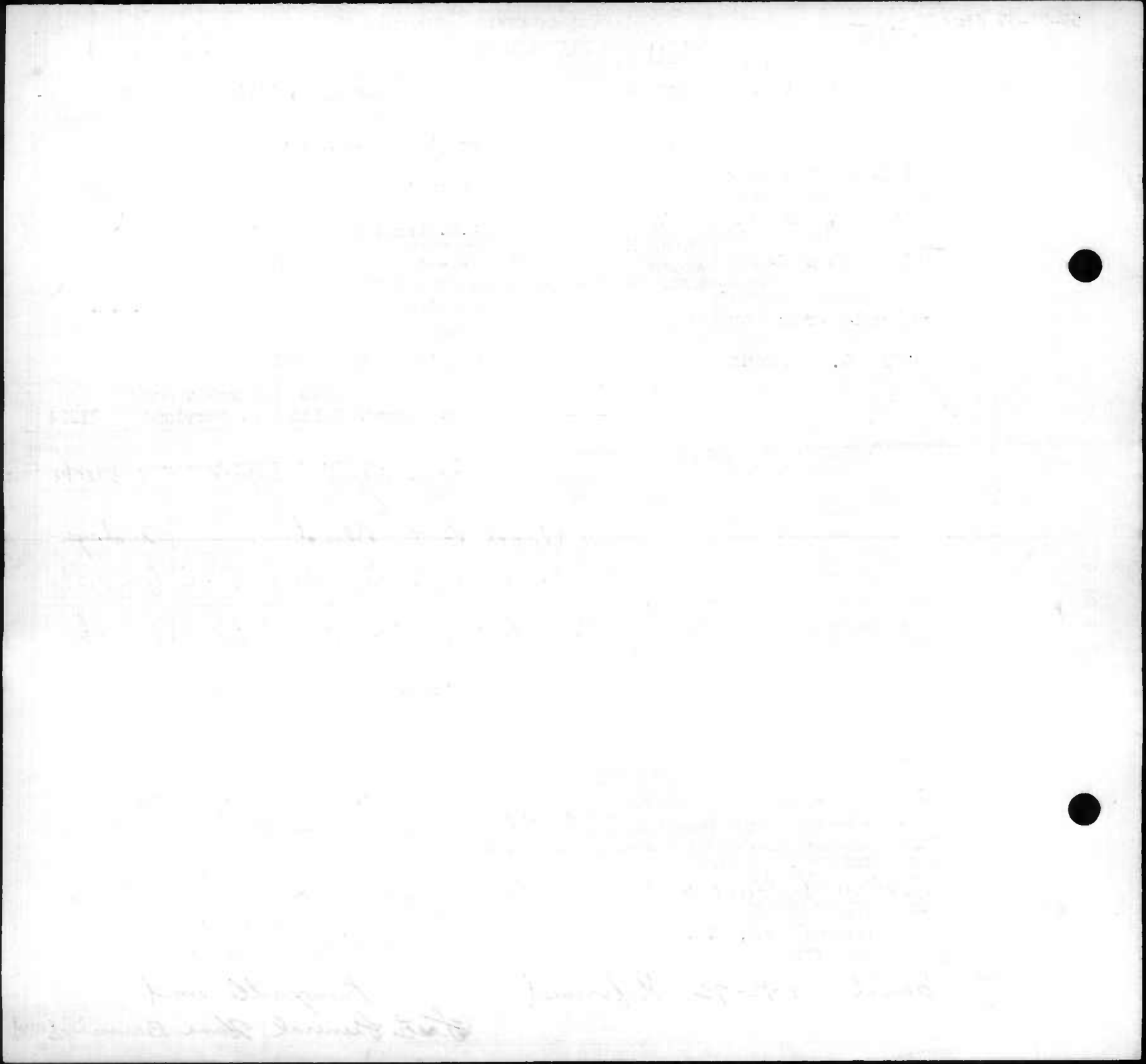
ADDRESS

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

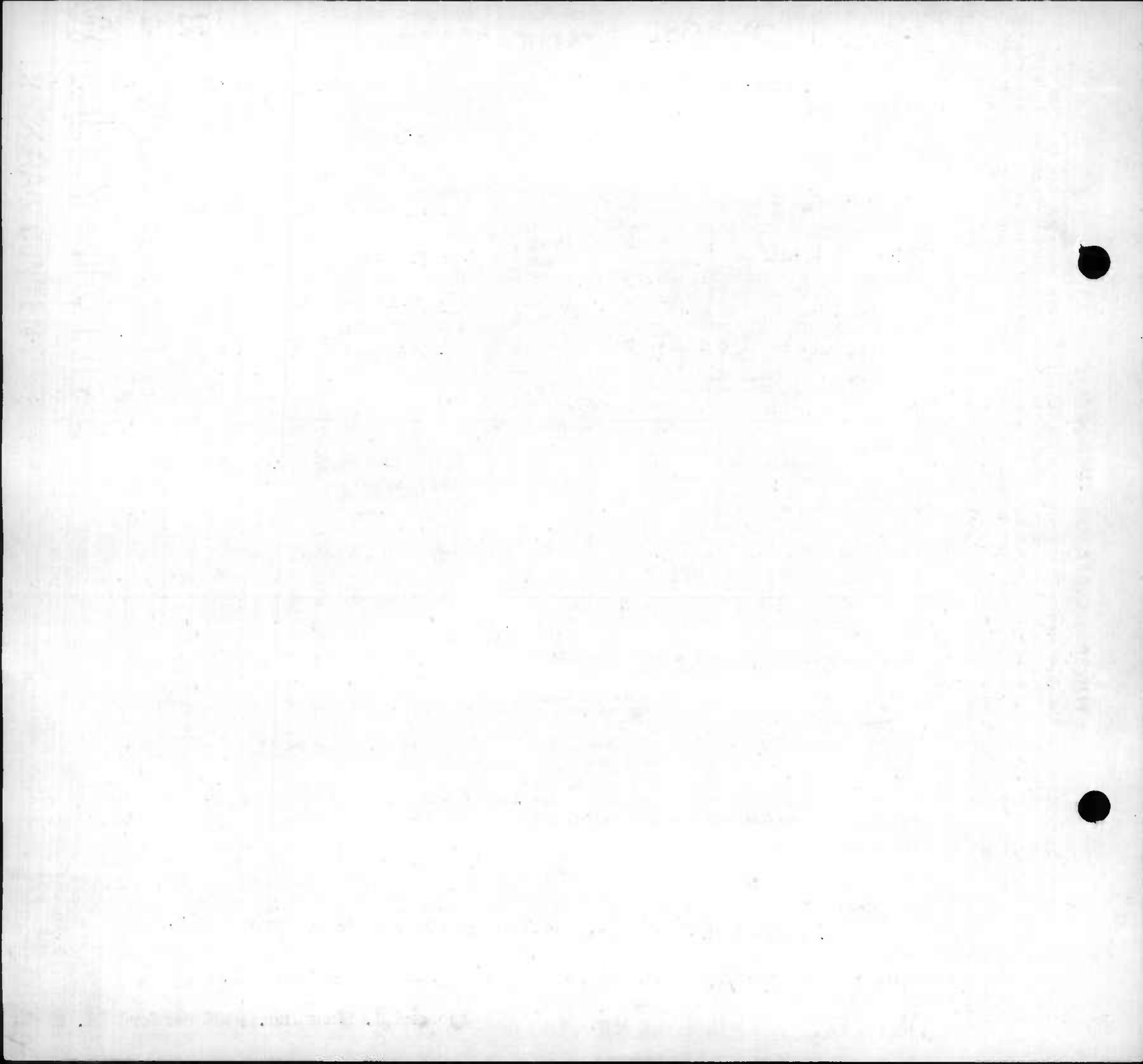
72 00380



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00381</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>JOSEPH COZZUBO</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>January 12, 1972</u> <u>5:05 AM</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>2904 Ailse Ave</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2733</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2904 Ailse Ave</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 12, 1899</u>	<b>9. AGE</b> (In years last birthday) <u>72</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>painter</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>ITALY</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>ITALY</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>american</u>		<b>13. FATHER'S NAME</b> <u>Michael Cozzubo</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucia Romeo</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>215050323</u>		<b>17. INFORMANT</b> <u>son</u>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>19. CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <u>Myocardial Infarction</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Coronary arteriosclerosis</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) PLEURAL EFFUSION</b>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>no</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>no</u>
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>JUN 1960</u> <b>19</b> <b>to</b> <u>JAN 11</u> <b>19</b> <b>72.</b> <b>that (I) (we) last saw the deceased alive on</b> <u>JAN 11</u> <b>19</b> <b>72</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Sebastian Russo</u>		<b>23B. DATE SIGNED</b> <u>JAN 12, 1972</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>SEBASTIAN RUSSO M.D.</u>
<b>23D. ADDRESS</b> <u>5017 Harford Rd. Baltimore Md</u>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		
<b>24B. DATE</b> <u>1/15/72</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Gardens of Faith Cemetery</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore Maryland</u>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 14 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>Donald J. Duck</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Donald J. Duck Inc. 5305 Harford Rd. 21214</u>



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>KENNETH D. HASLUP Sr.</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2906 Rueckert Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 11, 1972 4:30 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 3, 1928</b>				10. AGE (In years last birthday) <b>44</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>George J. Haslup</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2733</b>	
15. MOTHER'S MAIDEN NAME <b>Ruth Eckhardt</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
17. SOCIAL SECURITY NO. <b>217-22-0253</b>				18. INFORMANT <b>Mrs. Patricia D. Haslup Same</b>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hanging</b>				20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(B) _____</b> <b>(C) _____</b>			
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
23. DATE OF OPERATION <b>2</b>				24. CONDITION FOR WHICH OPERATION WAS PERFORMED			
25. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Basement apartment</b>			
27. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>January 9-11, 1972 ? m.</b>				28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2906 Rueckert Avenue 2733</b>			
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				30. HOW DID INJURY OCCUR? <b>Subject hanged himself</b>			
31. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				32. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
33. ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>				34. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
35. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				36. DATE SIGNED <b>1/12/72</b>			
37. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				38. DATE <b>1/14/72</b>			
39. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>				40. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
41. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>				42. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>			
43. FUNERAL DIRECTOR <b>5305 Harford Rd.</b>				44. ADDRESS			



Jan. 3, 1935

1902 January 1st

George J. Harding

USA

Harding

North Rockford

W. J. Davis Co.

Harding

217-22-0253 Mrs. Patricia G. Harding

to

Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding

Subject: Harding



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-326 BIRTH NO.		72 00383 BALTIMORE CITY HEALTH DEPARTMENT		72 00383 REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Ida NMN Wittgreffe</b>			2. DATE AND HOUR OF DEATH <b>January 12, 1972 10:15 PM.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 99 Union Memorial Hospital (D.O.A.)</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2743</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3209 Moravia Rd</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1890</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Lacher</b>			14. MOTHER'S MAIDEN NAME <b>Emma Schott</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-05-4225B</b>		17. INFORMANT <b>Charles F Wittgreffe</b>
			ADDRESS <b>Same</b>		
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion</b> 1 day			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive CV Disease</b> Almost 3 yrs			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>1/12</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/21</b> 19 <b>69</b> to <b>1/12</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel Morrison</b>				23B. DATE SIGNED <b>1/13/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Samuel Morrison M.D.</b>				23D. ADDRESS <b>11 East Chase St Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00384	
7-651 72 00384				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ARTHUR WILLARD FRAMPTON		JANUARY 7-1972 9 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 415 S. BENTALOU ST				B. COUNTY BALTIMORE	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 415 S. BENTALOU ST.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 13-1905	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) CENTERVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
10B. KIND OF BUSINESS OR INDUSTRY MARYLAND DRY DOCK			13. FATHER'S NAME ARTHUR A. FRAMPTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-45-1569		14. MOTHER'S MAIDEN NAME LOLA C. LISTER
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY CA			17. INFORMANT SISTER RENA E. LANCASTER RIVERVIEW RD		
19. 1621 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH abt 1 year		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/2 1971 to 1/7 1972, that (I) (we) last saw the deceased alive on 1/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. P. WILLIAMSON II MD				23B. DATE SIGNED 1/10/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 6550 BALTIMORE NATIONAL PIKE BALTIMORE 28, MARYLAND	
24A. BURIAL (CREMATION) REMOVAL (Specify)		24B. DATE 1-10-72		24C. NAME OF CEMETERY OR CREMATORY LOUDEN PARK	
25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972		25B. NAME OF REGISTRAR 972000		25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME-1216 S. CHARLES ST.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00385</u>
M-350 72 00385		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>LOUISE MADDEN</u>		2. DATE AND HOUR OF DEATH <u>1/11/72</u> <u>2:30 PM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2004 BOONE ST.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1102</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>524 N. CHAS. ST.</u>		
5. SEX <u>F</u>	6. RACE <u>NEGR</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/01</u>	9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAID</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILIES</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHAS. ROBINSON</u>		
14. MOTHER'S MAIDEN NAME <u>EMMA P.</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>and known</u>		17. INFORMANT <u>MORPHELA WINSTON</u> ADDRESS <u>2504 WOODBROOK LN</u>		
18. <u>481X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Citral Pulmonary Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>3 days</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/13/70</u> 19 to <u>1/11/72</u> 19, that (I) (we) last saw the deceased alive on <u>1/11/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Francis W. Glick</u>		23B. DATE SIGNED <u>1/12/72</u>		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/17/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT.</u>
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DPT. <u>JAN 14 1972</u>		
25B. NAME OF REGISTRAR <u>207.20</u>		25C. FUNERAL DIRECTOR <u>CORREAN FIBERH HONE</u> ADDRESS <u>1701 M. CULLOH'S BALTO., MD.</u>		

[illegible]



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CONNIE Louise <del>HOBBS</del> Hobbs</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 8, 1972</b>		Hour <b>6:45</b> A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION) <b>University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 8, 1972</b>		Hour <b>6:45</b> A.M.
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>P.G.</b> C. CITY OR TOWN <b>Oxon Hill</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>912 Palmer Rd.</b>		
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. DATE OF BIRTH <b>4-23-50</b>		10. AGE (In years last birthday) <b>21</b>	11. BIRTHPLACE (State or foreign country) <b>Maine</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Hutsko</b>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>D.C. Gov't.</b>		15. MOTHER'S MAIDEN NAME <b>Leona Parks</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Kenneth R. Hobbs, Husband, Same as</b>
19. <b>E812.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>1-8-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Int. 495-1500 feet east of 414--Temple Hill, Md.</b>
22D. TIME OF INJURY (APPROX.) <b>1-8-72 2:12 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto which struck stopped auto in rear</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-8-72</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Forest Hills Memorial Gardens Resurrection Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Clinton, P.G., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		
25B. NAME OF REGISTRAR <b>Robert E. Wilhelm</b>		25C. FUNERAL DIRECTOR <b>Robt E. Wilhelm 4308 Suitland, Rd., Suitland, Md.</b>		

1/25/72-

Correction letter.

ABC



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-623		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00387	
72 00387		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Robert W. Creighton</u>		2. DATE AND HOUR OF DEATH <u>6:05 P.M. 1-11-72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore, Inc., Baltimore, Md. 21215</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Belvedere Av. #15</u>			
5. SEX <u>male</u>	6. RACE <u>caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1887</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Not known</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Not known</u>			
14. MOTHER'S MAIDEN NAME <u>Not known</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>218-07-19961</u>		17. INFORMANT <u>Medical record, Sinai Hospital</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or condition which caused death) <u>Heart failure</u> DISEASES OR CONDITIONS, if any, leading rise to the above cause of death, stating the UNDERLYING CONDITION last. <u>Sepsis &amp; low resistance</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Heart failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis &amp; low resistance</u> (C) <u>Wound infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>14 days</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Fracture @ hip with nailing</u>					
19A. DATE OF OPERATION <u>12-7-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>fracture @ femoral neck</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Nursing home</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>Yes</u>		21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Belvedere Ave., 9-05</u>	
21D. TIME OF INJURY (Approx.) <u>11-24-71 1:45 evening</u>		21E. HOW DID INJURY OCCUR? <u>fell out of wheel chair</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>12-6-71</u> to <u>1-11-72</u> that (I) (we) last saw the deceased alive on <u>1-11-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Paicha Phattiyakul M.D.</u>		23B. DATE SIGNED <u>1-11-72</u>		23C. PHYSICIAN'S NAME (Type) <u>PAICHA PHATTIYAKUL, M.D.</u>	
23D. ADDRESS <u>Sinai Hospital, Baltimore, Md 21215</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Clon-Bonnie, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>		25B. NAME OF REGISTRAR <u>John J. ...</u>		25C. FUNERAL DIRECTOR <u>Walter J. ...</u>	

Adm. 11/12/21 to House in the Pines . . . .

Prev. Address 801 Gorsuch Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00388</u>	
BIRTH NO. <u>B-346</u>				72 00388	
1. NAME OF DECEASED (If not Print)			2. DATE AND HOUR OF DEATH		
BUTLER, STEPHEN CHARLES			JANUARY 10, 1972 12:13 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <u>40</u>			A. STATE <b>MARYLAND</b> B. COUNTY <u>2572</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b>			6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>10/23/90</b>			9. AGE (In years last birthday) <b>81</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>GEORGE BUTLER</b>			14. MOTHER'S MAIDEN NAME <b>( )</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			16. SOCIAL SECURITY NO. <b>213 10 0437</b>		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, athenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio Sclerotic Cardiovascular Disease</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>JANUARY 9, 1972</u> to <u>JANUARY 10, 1972</u> that (X) (we) last saw the deceased alive on <u>JANUARY 10, 1972</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE <i>V. Benavides</i>				23B. DATE SIGNED <b>01-10-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>VICTOR BENAVIDES, M.D.</b>				23D. ADDRESS <b>BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>1/13/1972</b>		<b>Loudon Park</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JAN 14 1972</b>		<b>W. E. G. M.D.</b>		<b>G. Truman Schwab</b>	
ADDRESS <b>3512 Frederick Ave.</b>					

11.11.1951

11.11.1951

11.11.1951

11.11.1951

11.11.1951

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

Thomas Kanias

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
OR INSTITUTION

00 508 S. Hanover St.

## 2. DATE OF DEATH

Known ☒ Estimated ☐

Month Day Year

1

6

72

Hour

6:40 p.m.

## 3. DATE

PRONOUNCED DEAD

Month Day Year

1

6

72

Hour

6:40 p.m.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

2201

## 6. SEX

male

## 7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

## C. CITY OR TOWN

Balto.

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

Dec. 25, 1926

## 10. AGE (In years)

48

## 11. BIRTHPLACE (State or foreign country)

Binghamton, New York

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## E. STREET AND NUMBER

508 S. Hanover Street

## 13. FATHER'S NAME

Theodore Kanias

## 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housepainter

## 15. MOTHER'S MAIDEN NAME

painting

Jennie Novobilski

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

## 17. SOCIAL SECURITY NO.

089-18-2773

## 18. INFORMANT

Mary Fiato

## ADDRESS

Binghamton, New York

## 19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Arteriosclerotic cardiovascular disease

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/7/72

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

Jan. 15, 1972

## 24C. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

## 24D. LOCATION (City, town, or county) (State)

Johnson City Broome New York

## 25A. DATE REC'D BY HEALTH DEPT

JAN 14 1972

## 25B. NAME OF REGISTRAR

Robert E. Gable, M.D.

## 25C. FUNERAL DIRECTOR

## ADDRESS

324 N. Main Street  
Hampstead, Maryland

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00390	
7-655 72 00390				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Freeman, Clinton L.</i>		2. DATE AND HOUR OF DEATH <i>1.12.72 9<sup>00</sup> A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE B. COUNTY <i>717 Roundview Rd. - Md. 2552</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>43</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>12.23.1915</i>		9. AGE (In years lost birthday) <i>76</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>SAM (Dec.)</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie I. (Dec.)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>717-12-8732-A</i>		17. INFORMANT <i>Louise Baker Granddaughter in law. Same as above</i>	
18. <i>513X I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>lung abscess</i>		<i>One week</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>senility</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <i>senility</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>a bel. pain poss. chronic cholecystitis</i>		<i>6 Months.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>—</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>12.22.71</i> 19 <i>71</i> to <i>1.12.72</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8.30 AM 1.12.72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>G. G. Salmassi</i> M.D.		23B. DATE SIGNED <i>1.12.72</i>		23C. PHYSICIAN'S NAME (Type) <i>G. G. Salmassi</i> M.D.	
23D. ADDRESS <i>3001 S. Hanover St. Baltimore, Md. 21230</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-15-72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 14 1972</i>	
25B. NAME OF REGISTRAR <i>John J. ...</i>		25C. FUNERAL DIRECTOR <i>Charles P. Price</i>		ADDRESS <i>661 W. ... St.</i>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

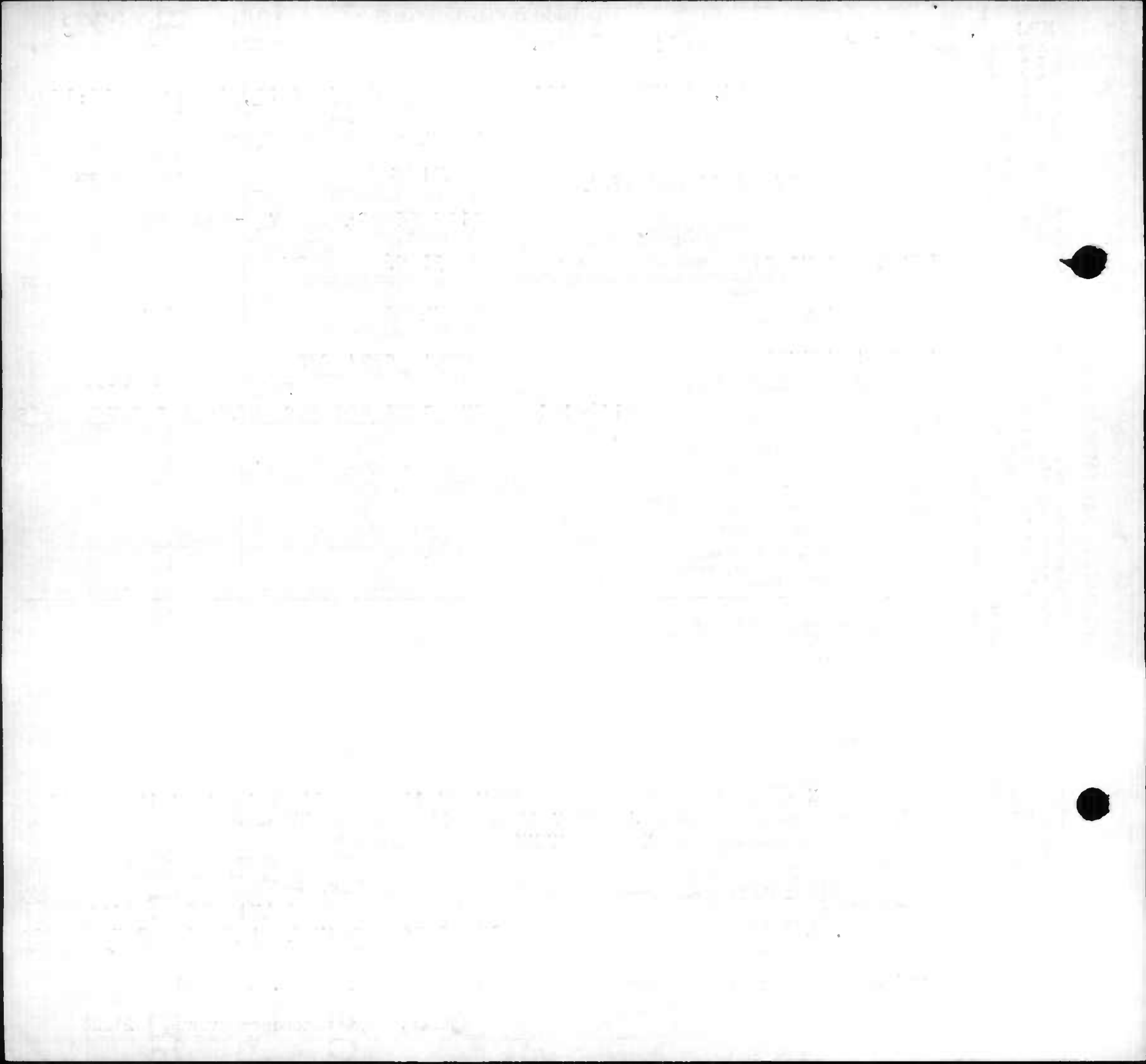
Baltimore City Health Department				REG. NO. 72 00391	
H-536 72 00391				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ROLLIN HENDRICKSON</u>			2. DATE AND HOUR OF DEATH <u>1-9-72</u> <u>10.30 p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>43 SOUTH BALTIMORE GENERAL HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2543</u>		
5. SEX <u>male</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>			8. DATE OF BIRTH <u>9-22-04</u> 9. AGE (in years last birthday) <u>67</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>FRANK HENDRICKSON</u>			14. MOTHER'S MAIDEN NAME <u>HENRIETTA HARDY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. -A <u>21503-3692</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. AMERICAN</u>
18. <u>750.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute (L) Cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular Disease</u> <u>HYPERTENSIVE ARTEROSCLEROTIC</u> (B) <u>CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DIABETES MELLITUS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>- yrs.</u> <u>- 20 yrs.</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> 19 <u>71</u> to <u>1-9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edith H. Dalgo</u>			23B. DATE SIGNED <u>1-9-72</u>		23C. PHYSICIAN'S NAME (Type) <u>EDITH H. DALGO</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>1-13-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CARVER MEMORIAL PK.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>			25B. NAME OF REGISTRAR <u>Charles H. Rice</u>		25C. FUNERAL DIRECTOR'S ADDRESS <u>661 W. Barré St.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00392</span>	
G-620 72 00392				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GERWIG, EDITH REBECCA		JANUARY 12, 1972 10:15P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2125 FERNGLEN WAY --Westview			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 31 96	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME JOHN BIRKMEYER		14. MOTHER'S MAIDEN NAME AMELIA SPRINGER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213481919		17. INFORMANT ADDRESS BALTIMORE MD 21229 ST AGNES RECORDS WILKENS & CATON AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.3 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure (B) Artherosclerotic Heart Disease (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month: 1 Day: 1 Year: 1 Hour: 1) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from JANUARY 12 1972 to JANUARY 12 1972 that (X) (we) last saw the deceased alive on JANUARY 12 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		23A. SIGNATURE Joseph Doon Lee M.D. 23B. DATE SIGNED January 12, 1972	
23C. PHYSICIAN'S NAME (Type) DR. LEE MD		23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVES		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 1/15/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972		25B. NAME OF REGISTRAR Robert F. Saylor M.D.		25C. FUNERAL DIRECTOR Otzke, 7630 Edmondson Avenue 21228	



72 00393 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>J. JACOB HASPERT</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 12, 1972</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 12, 1972</b>		Hour <b>2:40 P. M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Catonsville</b> <del>Baltimore</del>			
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>10/9/09</b>		10. AGE (In years last birthday) <b>62</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>late Jacob Haspert</b>		14. STREET AND NUMBER <b>317 Gralan Road</b>	
15. MOTHER'S MAIDEN NAME <b>Late Anna Kahler</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>214-03-1467</b>	
18. INFORMANT <b>Mrs. Jacob J. Haspert, 317 Gralan Road</b>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 13, 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Gardens</b>	
24D. LOCATION (City, town, or county) (State) <b>Dulaney Valley, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Gandy, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 1630 Edmondson Ave., 21228</b>			

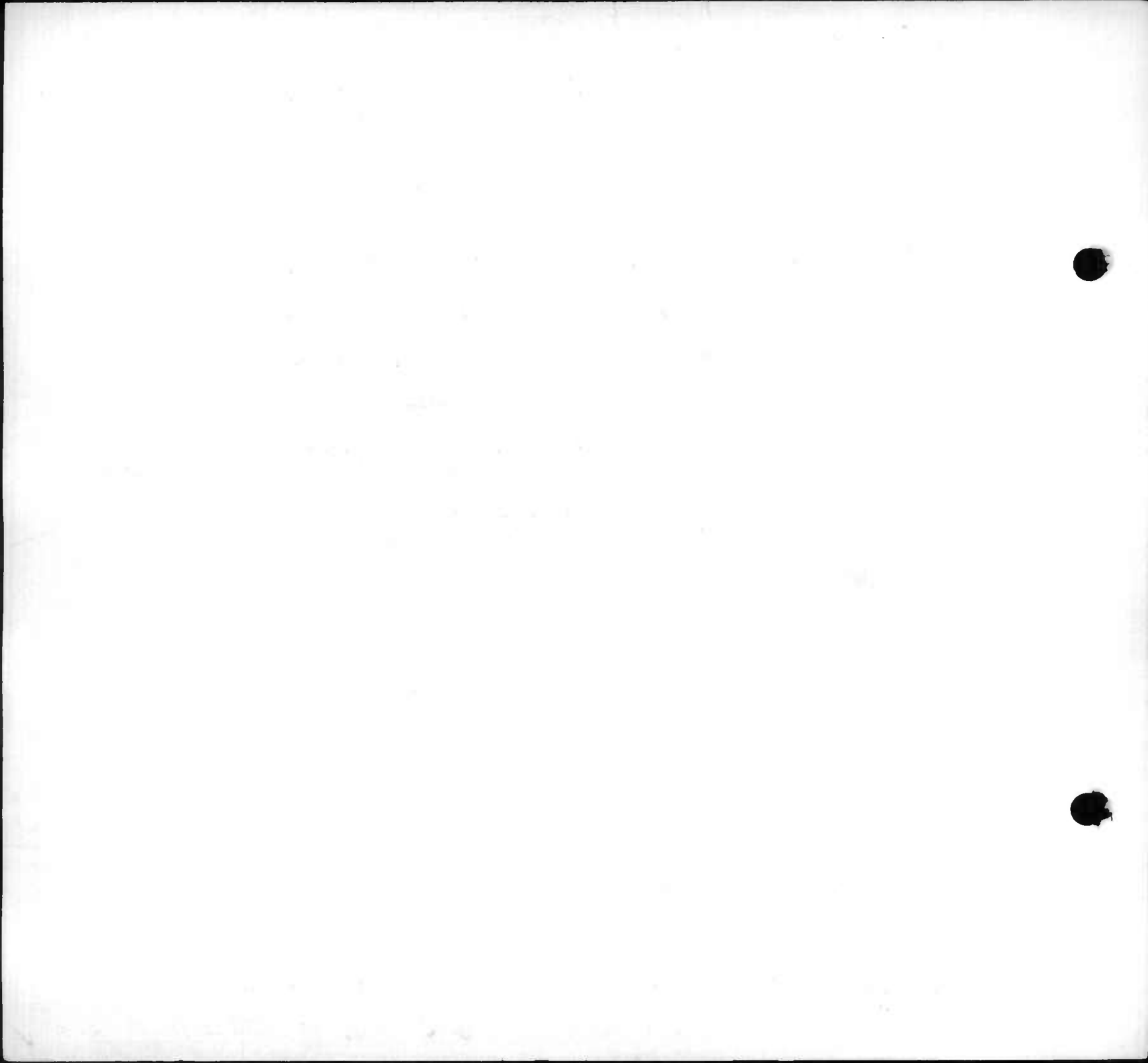




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>L-230</b></span> <span><b>72 00394</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>72 00394</b></span> </div>			
BIRTH NO. <b>L-230</b> 1. NAME OF DECEASED (Type or Print) <b>ROBERT L. LOCKETT</b>		2. DATE AND HOUR OF DEATH <b>1/17/72 6:00 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 MD. GENL HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1702</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1102 Druid Hill Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-24-07</b>
9. AGE (In years last birthday) <b>64</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital orderly</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Halifax Co. North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob Lockett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Greene</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>EWAT Johnson</b>		ADDRESS <b>1004 Dorsey Ave. Balt.</b>	
18. <b>519.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMPHYSEMA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CITRONIC OBSTRUCTIVE LUNG DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7MS</b> <b>7MS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Michael J. Lutter MD</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>1-17-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>MT Calvary Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel City Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>W. J. Lutter</b>	
25C. FUNERAL DIRECTOR <b>W. J. Lutter</b>		ADDRESS <b>925 E North Ave</b>	



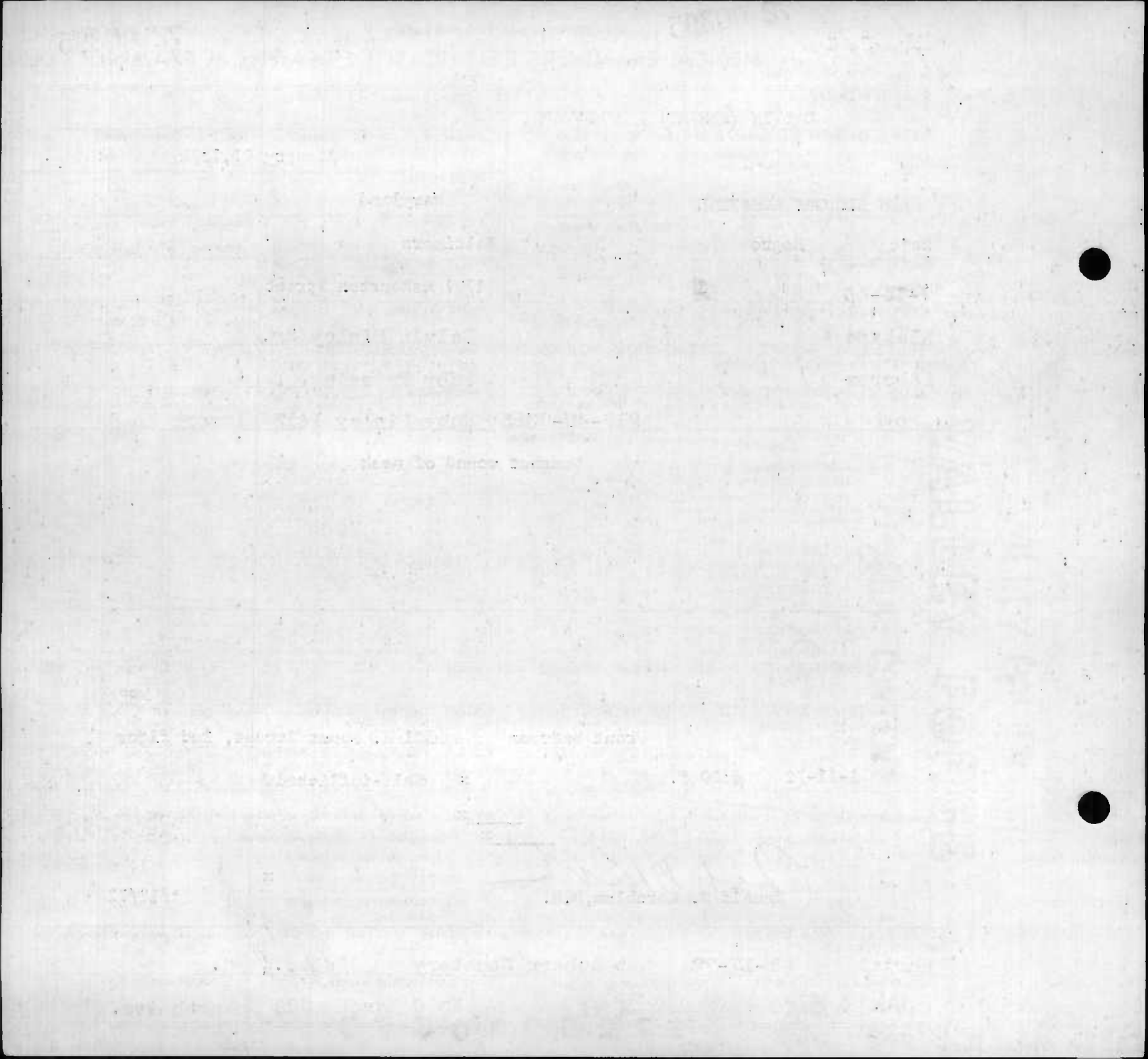


BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CALVIN (FENLEY) FINLEY JR.</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>January 11, 1972 6:40 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1506</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>7-14-45</b>		10. AGE (In years last birthday) <b>26</b>		E. STREET AND NUMBER <b>1701 Ashburton Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Calvin Finley Sr.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Ruby Pressley</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>219-40-2385</b>		18. INFORMANT ADDRESS <b>Ruby Finley 1413 Kitmore Road</b>	
19. CAUSE OF DEATH <b>E 9551X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>1-11-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Front bedroom</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>501 N. Mount Street, 2nd floor 1603</b>	
22D. TIME OF INJURY (APPROX.) <b>1-11-72 6:00 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Self-inflicted</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/12/72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C March 928 E North Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>C-652</span> <span>72 00396</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>CERTIFICATE OF DEATH</span> </div>		REG. NO. <span style="float: right;">72 00396</span>	
BIRTH NO. <span style="float: right;">1</span>			
1. NAME OF DECEASED (Type or Print) <b>Emma Jean Carmichael</b>		2. DATE AND HOUR OF DEATH <b>Jan. 12 1972 3<sup>05</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hosp.</b> ADDRESS OR LOCATION <b>3001 S. Hanover St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2505</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1410 Chesapeake Court</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-21</b> 9. AGE (in years last birthday) <b>50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charlie Brown</b>		14. MOTHER'S MAIDEN NAME <b>Levator Miles</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>237-30-8707</b>	
17. INFORMANT <b>MARRISELLA DUKES</b>		ADDRESS <b>738 REEDBIRD AVE</b>	
18. <b>400.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebrovascular Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic Vascular Disease sev. years</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Malignant Hypertension 1 year?</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>19 71</b> to <b>Jan 12 1971</b> , that (I) (we) last saw the deceased alive on <b>Jan 12 19 71</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above <b>(I) (We) (did) (did not) view the body after death.</b>			
23A. SIGNATURE <b>Colvin C. Carter, M.D.</b>		23B. DATE SIGNED <b>Jan 12, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Colvin C. Carter M.D.</b>		23D. ADDRESS <b>Baltimore Maryland 3001 S. Hanover Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-15-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel City Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>WM S MARCH</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>928 E NORTH AVE</b>			

25 April 1941

175

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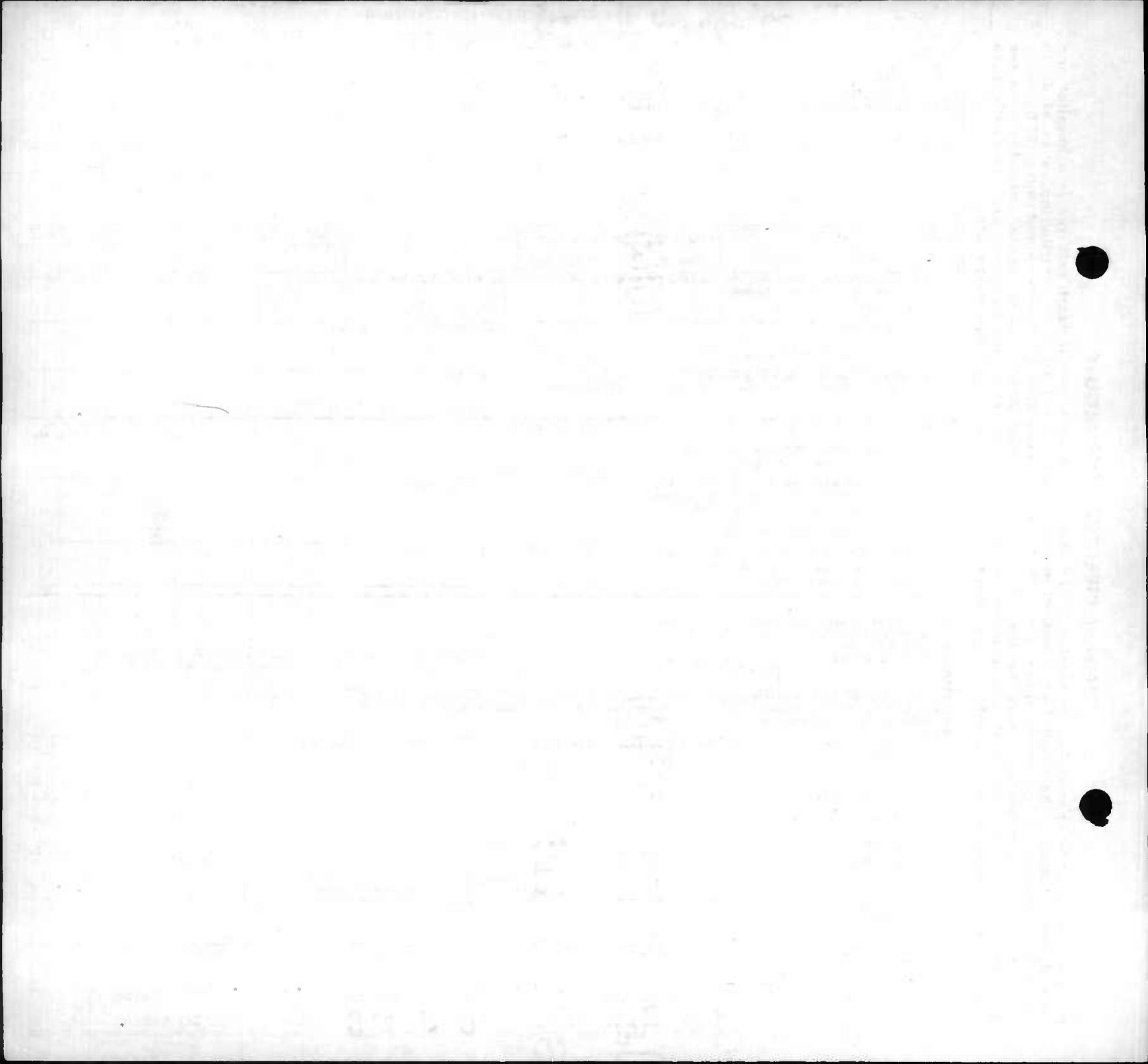
19th [illegible]

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00397	
CERTIFICATE OF DEATH					
BIRTH NO. 7-500		1. NAME OF DECEASED (Type or Print) <u>LAURETTA FRAIN, LORETTA</u>		2. DATE AND HOUR OF DEATH <u>1/11/72</u> <u>12:06 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER <u>1322 Eutaw Place</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/23</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Webster</u>			14. MOTHER'S MAIDEN NAME <u>Laura Johnson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Sarah Meekins 710 Greenmount Ave.</u>		
18. <u>427.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CH7, Asthma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1° Resp. Arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>72</u> to <u>1/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Martha L. Kopper, M.D.</u> DEGREE				23B. DATE SIGNED <u>1/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Martha L. Kopper, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-17-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Balto., Md.</u>		24E. STATE (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>		25B. NAME OF REGISTRAR <u>Rebecca J. 2 0 2 0 0</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm S March 928 E North Ave.</u>	

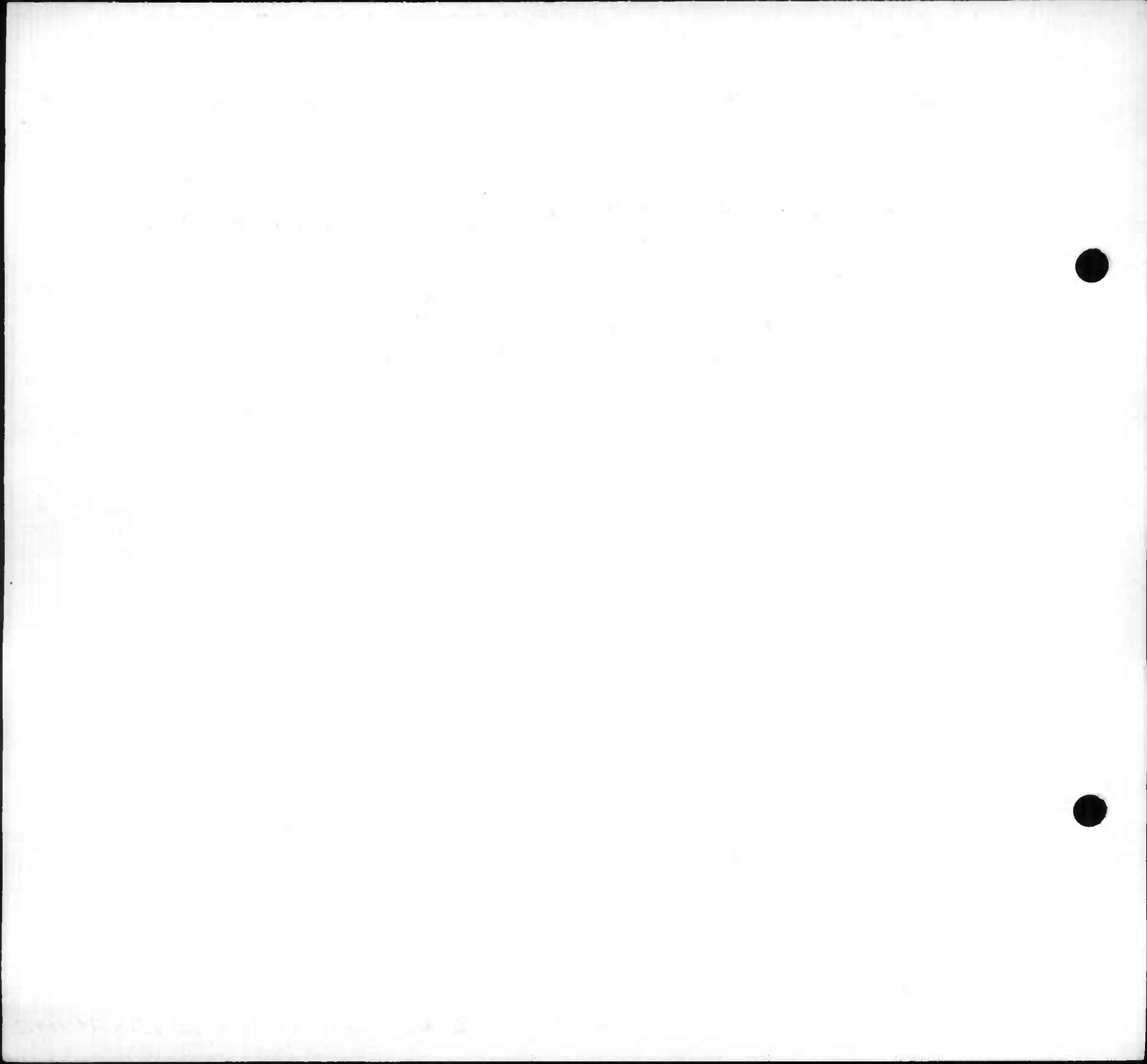




# FUNERAL DIRECTOR: IMPORTANT

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B-256 72 00398		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00398 REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>BUCKNER, William E.</b>		2. DATE AND HOUR OF DEATH <b>1-11-72 10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2001</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>212 N. MONROE STREET</b>			
5. SEX <b>Male</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04/25/23</b>	9. AGE (In years last birthday) <b>48 YRS</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired from Post Office</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JAMES BUCKNER</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>216 12-3942</b>		17. INFORMANT <b>CHART - B.S.H.</b>	
18. <b>571.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Hemorrhagic shock associated</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Hepatic Cirrhosis due to Bacterial Necrosis</b> <b>Liver Cirrhosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>January 11 1972</b> to <b>January 11 1972</b> that (H) (we) last saw the deceased alive on <b>January 11 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thien Thitivarana</b>		M.D. DEGREE <b>M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>THIEN THITIVARANA</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTON NATIONAL CEM</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>B. G. S.</b>		25C. FUNERAL DIRECTOR <b>WMPC MARCH</b>	
ADDRESS <b>928 E NORTH AVE</b>					

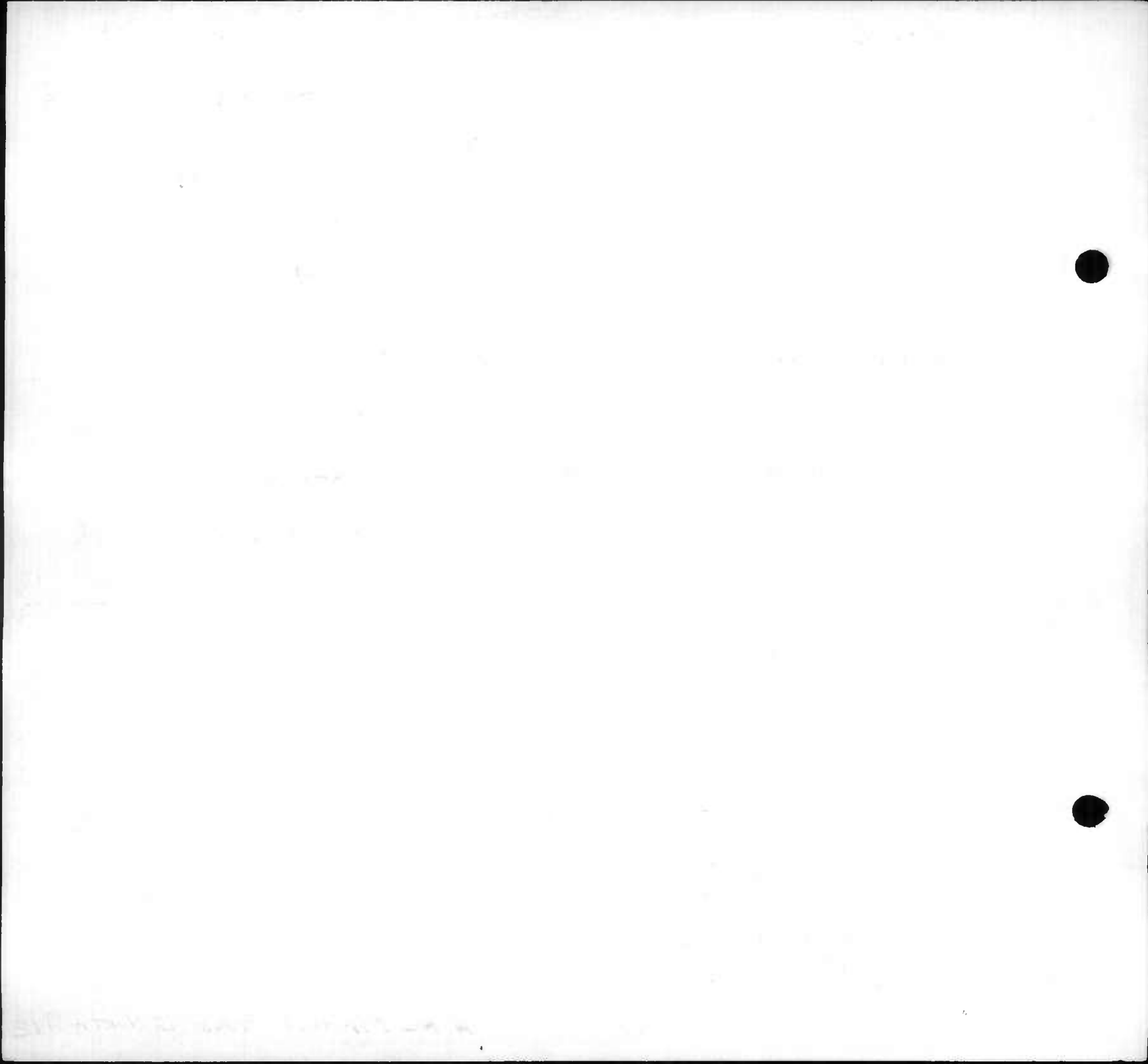




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00399</u>	
BIRTH NO. <u>H-400</u>		72 00399			
1. NAME OF DECEASED (Type or Print) <u>HILL, SHIRLEY A.</u>			2. DATE AND HOUR OF DEATH <u>JAN. 11, 1972</u> 1 <u>12:30</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL &amp; BALTIMORE</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1513</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2600 OSWEGO AVE.</u>		
5. SEX <u>F</u>	6. RACE <u>NEG</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/1941</u>	9. AGE (in years last birthday) <u>31</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>ARCER HILL</u>			14. MOTHER'S MAIDEN NAME <u>EMMA THOMAS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>EUNICE DICKERSON</u> ADDRESS <u>2600 OSWEGO AVE</u>	
18. <u>730X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PROB. MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>  <u>ONE THREE DAYS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>POSSIBLE GRAM NEGATIVE SEPSIS</u>			4 days		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> 19 <u>72</u> to <u>1/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Araceto T. Ordinario Jr. M.D.</u>			23B. DATE SIGNED <u>1/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ARACETO T. ORDINARIO, JR. M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1-15-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem</u>
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty. Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>			25C. FUNERAL DIRECTOR <u>WMC MARCH</u> ADDRESS <u>928 E NORTH AVE</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-622 72 00400		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00400	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print)		BORKOWSKI, MARGARET A. Margarita		2. DATE AND HOUR OF DEATH JANUARY 10, 1972 11:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY AA		5200	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MD. 21229		C. CITY OR TOWN SEVERN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER QUARTERFIEL RD, BOX 320 RT. #1			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-24-90	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOMEMAKING		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ANDREW GOULDIN		14. MOTHER'S MAIDEN NAME BARBARA (KREINER)		DEC 'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. 212079049		17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute Choleystitis lost to Diffuse Metastatic Adenocarcinoma B. DUE TO, OR AS A CONSEQUENCE OF: C. Pancreatic carcinoma or Break (not known) C. Pancreatic carcinoma or Break (not known)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 11-15-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED acute Choleystitis		20A. AUTOPSY? (Yes or No) Refused	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 8 1971 to JANUARY 10 1972 that (I) (we) last saw the deceased alive on JANUARY 10 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Atul Ahmad Qureshi		23B. DATE SIGNED 1.10.1972			
23C. PHYSICIAN'S NAME (Type) DR. QURESHI		23D. ADDRESS ST. AGNES HOSPITAL BALTO. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/14/72		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.	

1-13-1972 - Correction form from Funeral Director

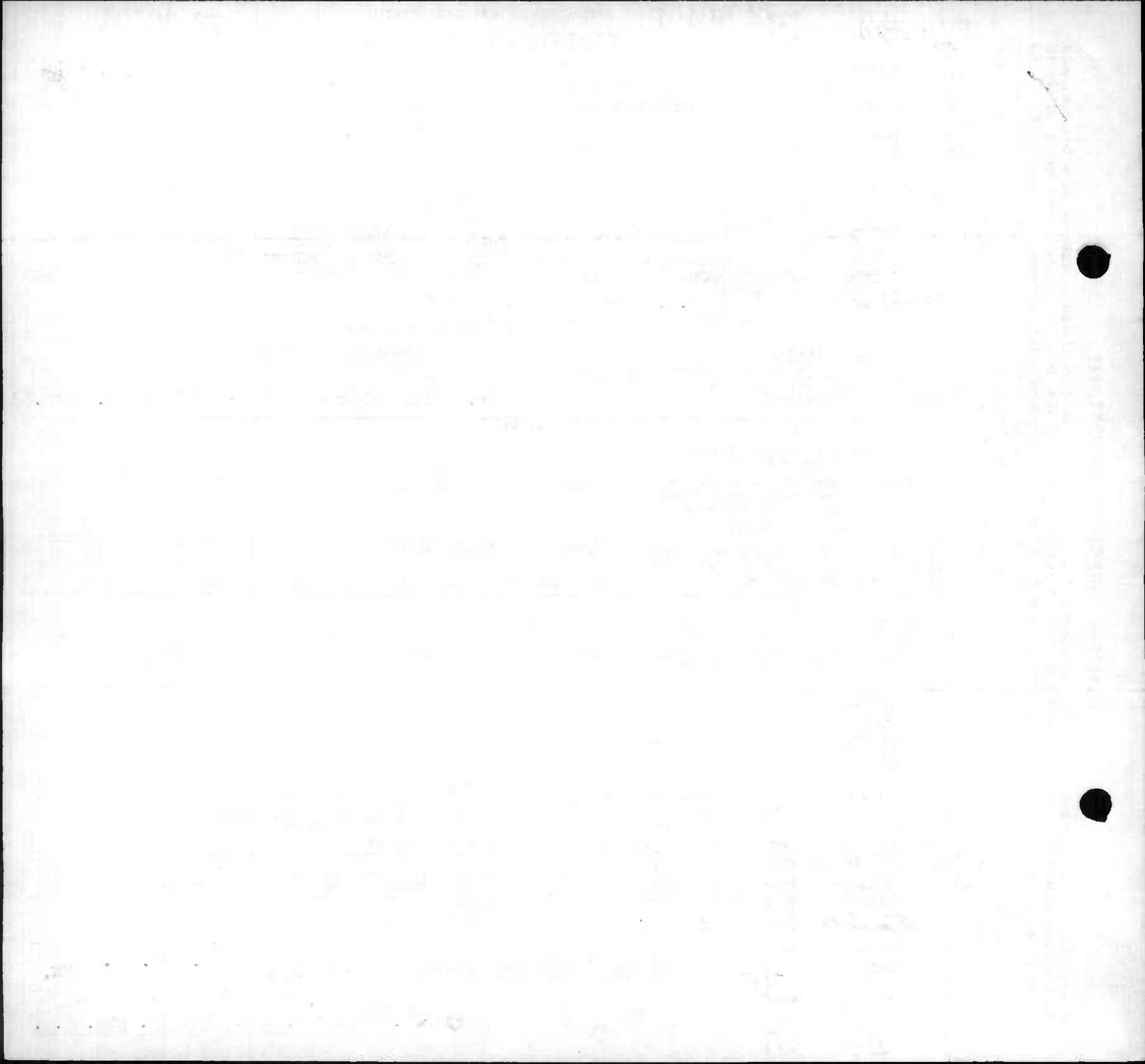
HS

DR. CURTIS  
ST. ANNE'S HOSPITAL  
JAN 19 1972

# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. 72-00401	
BIRTH NO. <b>L-340</b>		1. NAME OF DECEASED (Type or Print) <b>NACHANIEL LITTLE</b>		2. DATE AND HOUR OF DEATH <b>1/6/72 10:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>WASHINGTON</b> B. COUNTY <b>D.C.</b> C. CITY OR TOWN <b>V48</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b> <b>44 Baltimore, Md</b>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>Old Soldiers Home</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1895</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Listed man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>MAINE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Horace Little</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth (unknown)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Retired</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Dr. Peter Goldman 4609 Edgefield Rd. Beth. Md</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>YEARS</b>		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Aspiration pneumonia</b>					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/91</b> <b>1972</b> to <b>1/6/1972</b> that (I) (we) last saw the deceased alive on <b>1/6/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> DEGREE				23B. DATE SIGNED <b>1/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ronald W. Geckler</b> DEGREE				23D. ADDRESS <b>Union Memorial Hospital Baltimore, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Soldiers Home</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington D.C. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Pumphrey</b>		25C. FUNERAL DIRECTOR <b>B. Crase</b> <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00402	
5-560 72 00402		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John Scheiner		2. DATE AND HOUR OF DEATH 11/7/72 1:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3218 Putty Hill Avenue	
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 05-22-92 79 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10B. KIND OF BUSINESS OR INDUSTRY LAW	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George Scheiner		14. MOTHER'S MAIDEN NAME MARIA Pachia	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-30-7459	17. INFORMANT Family Records ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 11/9/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 12/31 1971 to 1/7 1972 that (I) (we) last saw the deceased alive on 1/7 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] DEGREE 23B. DATE SIGNED 11/7/72 23C. PHYSICIAN'S NAME (Type) CESAR VILMORAN INTERN DEGREE 23D. ADDRESS 3318 1/2 Calvert St. 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 1-10-72 24C. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY 24D. LOCATION BALTO MD 25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR G. H. Evanson ADDRESS 8802 Hartford Rd.			

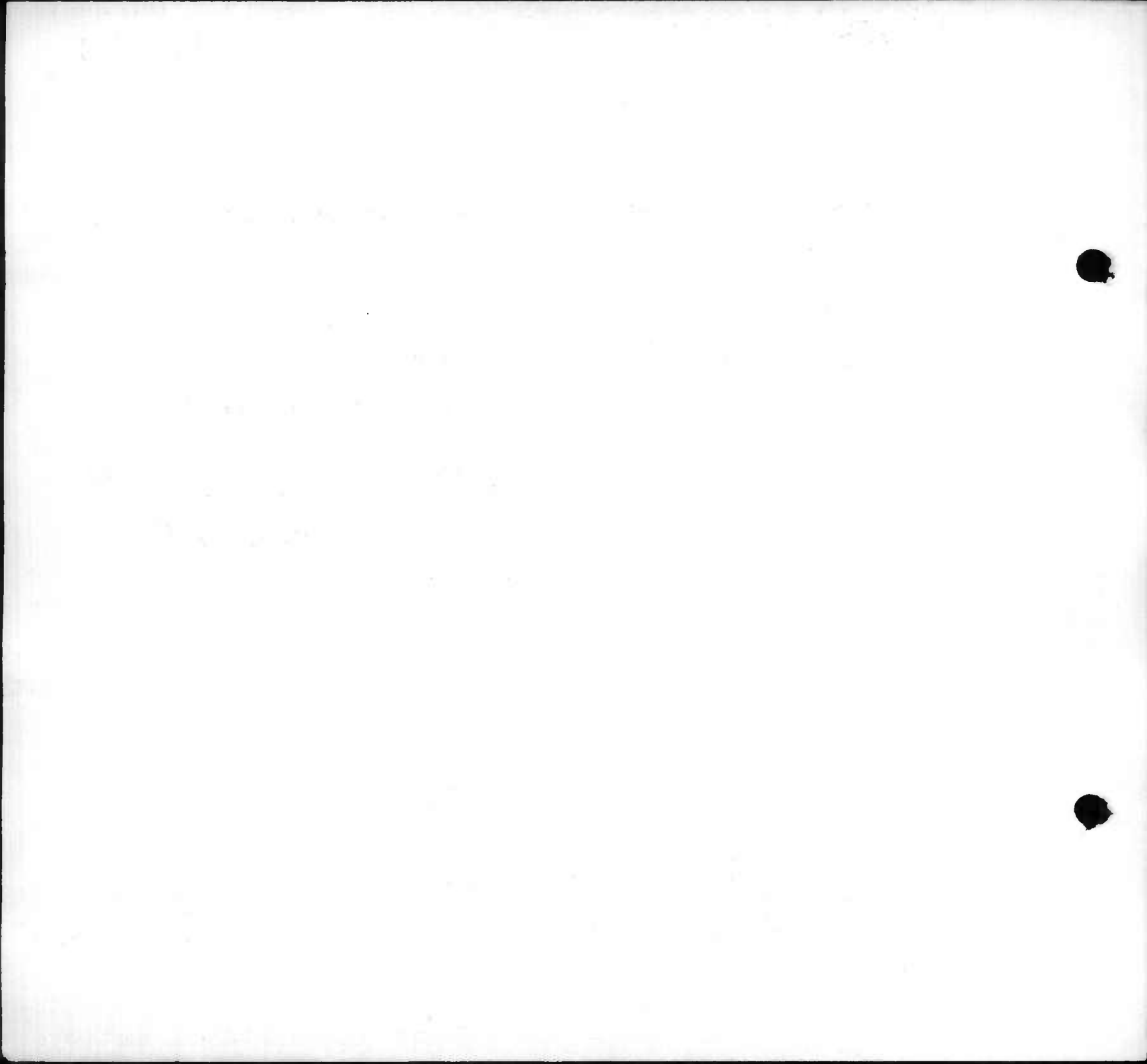
1007



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

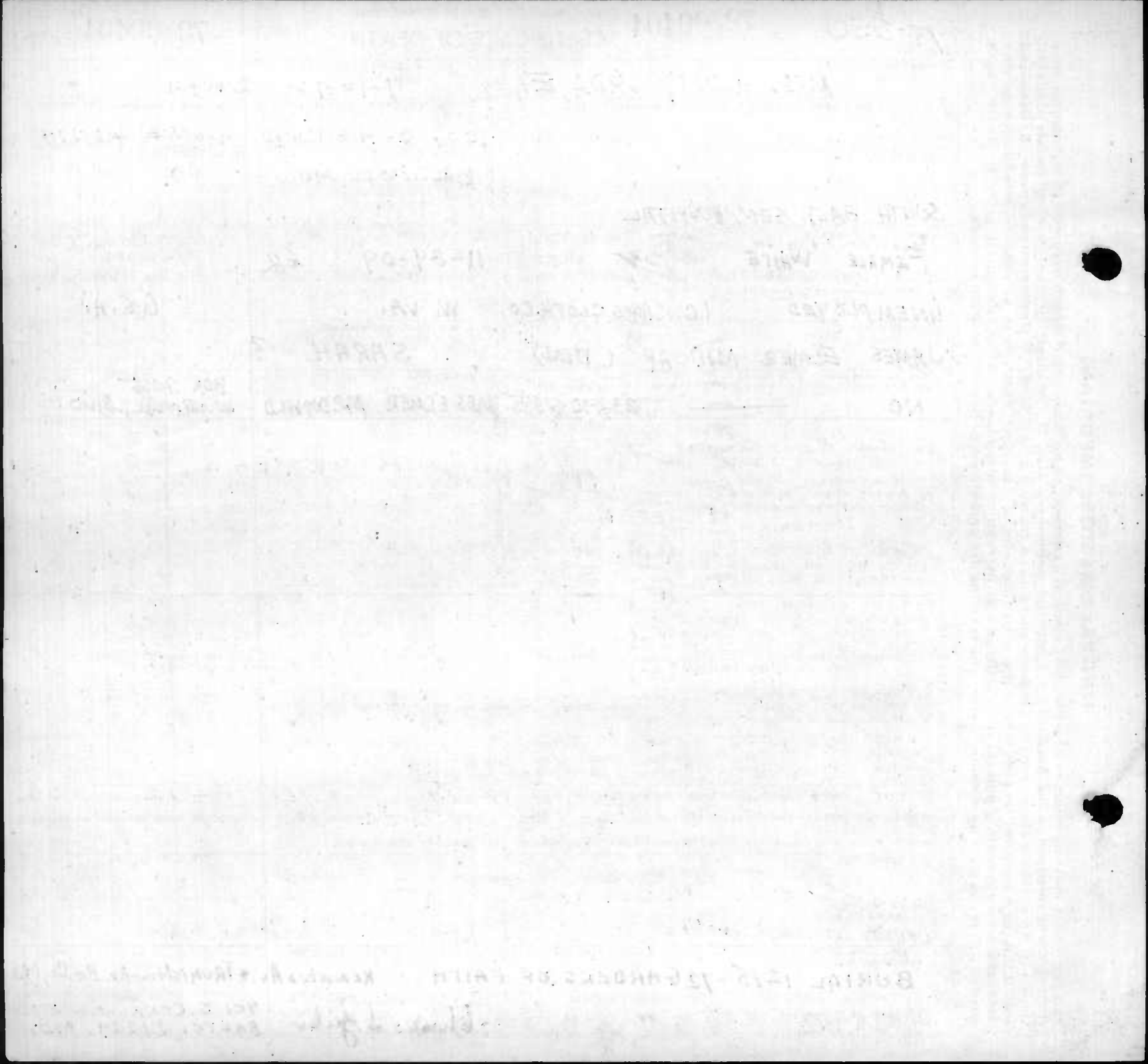
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00403</u>	
1. NAME OF DECEASED (Type or Print) <u>HENRY WILLIAMS</u>				2. DATE AND HOUR OF DEATH <u>1/10/72</u> <u>1</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4028 Woodhaven Ave</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1509</u>	
				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4026 Woodhaven Ave</u>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/</u>		9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lexington, Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>George Williams</u>		
14. MOTHER'S MAIDEN NAME <u>Mary</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs Eloise Williams, Same</u>		
18. <u>404X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial insufficiency</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/10/72</u> to <u>1/10/72</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>1/10/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Borofsky</u>				23B. DATE SIGNED <u>1/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. Borofsky</u>				23D. ADDRESS <u>4734 PARK Hgts Bldg MD 2415</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/16/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT Calvary Cemetery</u>	
24D. LOCATION <u>A A County Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>			
25B. NAME OF REGISTRAR <u>Adolph Halstead</u>		25C. FUNERAL DIRECTOR <u>Adolph Halstead</u>			
ADDRESS <u>1206 W north Ave</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-530 72 00401		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00401	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MRS. HUNT, VADA, E.,</b>			2. DATE AND HOUR OF DEATH <b>1-12-72 2:00 PM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALT. GEN. HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>1304 S. HIGHLAND AVENUE #21224</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE, MD. 21224</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2636</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-09</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>I.C. ISAACS CLOTH. CO.</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>	
13. FATHER'S NAME <b>JAMES ELMER MIDCAP (DEC.)</b>			14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>232-10-8585</b>		17. INFORMANT <b>MRS ELMER McDONALD - BOX: 2085 WINTERVILLE, Ohio.</b>	
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC CA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> 19 <b>71</b> to <b>1-12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> DEGREE			23B. DATE SIGNED <b>1-12-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>CARLOS N. PATALINGHAUS</b> DEGREE			23D. ADDRESS <b>SBGH BALT. MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-15-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>	
24D. LOCATION (City, town, or county) (State) <b>KENWOOD AV. &amp; TRUMPS MILL RD. BA. CO., MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>			
25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

58-15126 djr		72 00405		72 00405	
BIRTH NO. <b>W-123</b>				REG. NO. _____	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>WEBSTER, RAYMOND, G.</b>		<b>JANUARY 11<sup>th</sup> 1972</b>		<b>5<sup>30</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> 4940 Eastern Avenue Baltimore, Maryland				A. STATE <b>Maryland</b>	
				B. COUNTY <b>2611</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>406 South Bouldin Street 21224</b>					
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-24</b>	9. AGE (In years last birthday) <b>47</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Amer. Bridge Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>(Name) Arthur G. Webster</b>			14. MOTHER'S MAIDEN NAME <b>Minnie E. Sealover</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>218-18-3329</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH: Records Baltimore, Maryland 21224</b>	
18. <b>567.91</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTIC SHOCK</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>GENERALIZED PERITONITIS</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1/10/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERITONITIS</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/10/72</b> 19__ to <b>1/11/72</b> 19__ that (I) (we) last saw the deceased alive on <b>1/11/72</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Eduardo Barboza M.D.</b>				23B. DATE SIGNED <b>January 11, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDUARDO BARBOZA, M.D.</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore City Hospital, Baltimore, Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba. Co., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Barboza</b>		25C. FUNERAL DIRECTOR <b>901 S. Conkling St. Balto., 21224, Md.</b>	

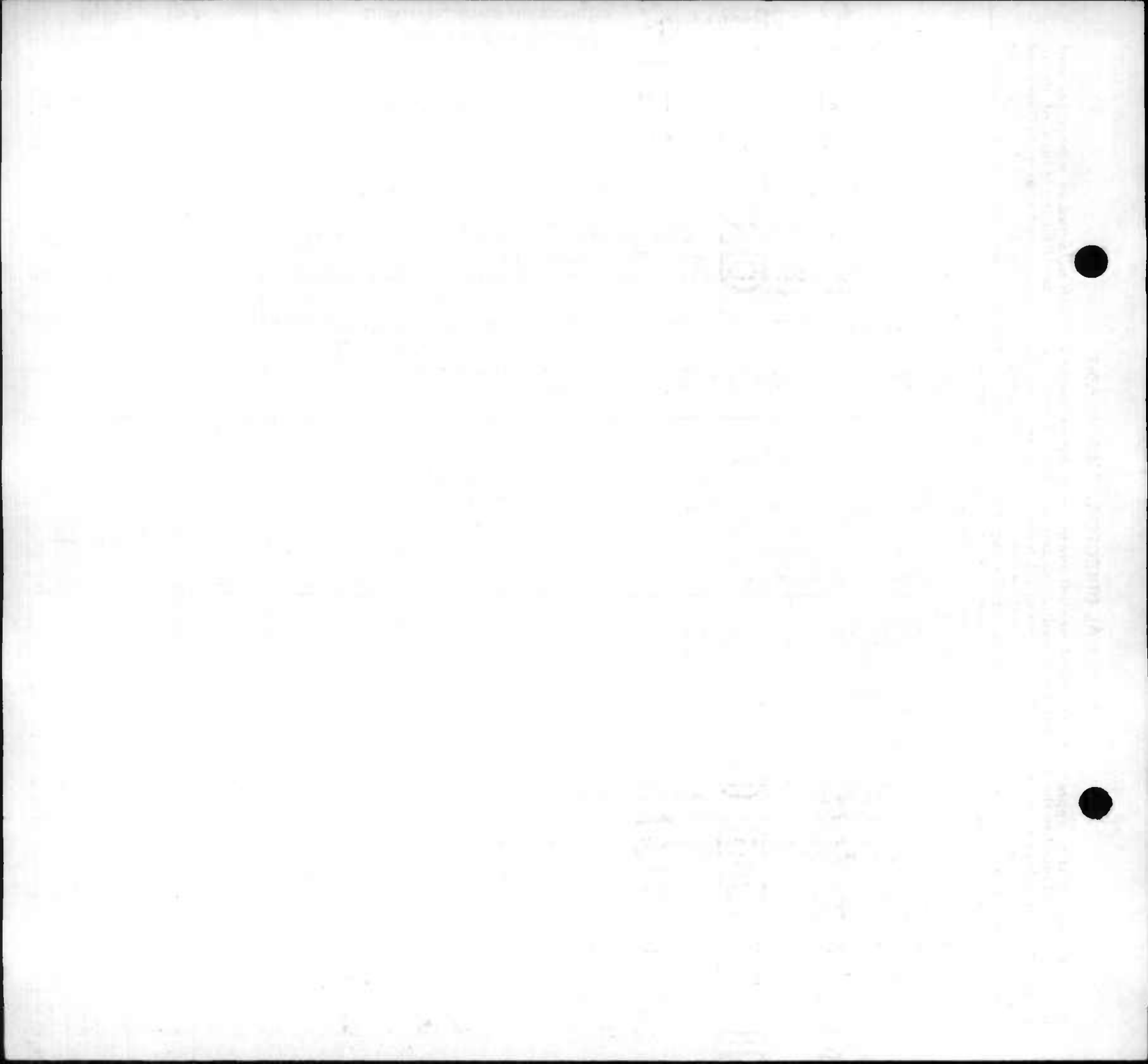
CONFIDENTIAL 8110 33-74453

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00406</span>				CITY OF BALTIMORE, MARYLAND CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">100406</span>	
1. NAME OF DECEASED (Type or Print) <b>PATRENA D. LEE</b>				2. DATE AND HOUR OF DEATH <b>1/10/72</b> <b>5:20 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Pinet Hosp. of Baltimore</b>				A. STATE <b>Md.</b> <b>1000 N. DuKeland St. 1606</b>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN <b>Balt.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1000 N. DuKeland St.</b>			
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/8/71</b>	9. AGE (In years last birthday) <b>0</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTH PLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>George Lee</b>			
14. MOTHER'S MAIDEN NAME <b>Alberta Varner</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Alberta</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>746.8</b> <b>Acute pulmonary edema</b> <b>Antecedent Causes</b> <b>? Congenital heart disease</b>				CAUSE OF DEATH <b>Acute pulmonary edema</b> <b>Antecedent Causes</b> <b>? Congenital heart disease</b>			
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Brain aneurysm</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>72</b> to <b>1/10</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Chingcong m.d.</b>						23B. DATE SIGNED <b>1/10/72</b>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>						24B. DATE <b>1/13/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>						24D. LOCATION (City, town, or county) (State) <b>A.A.C. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>						25B. NAME OF REGISTRAR <b>3927-2 0 0 0</b>	
25C. FUNERAL DIRECTOR <b>William S. Phillips</b>						25D. ADDRESS <b>1727 N. Monroe St.</b>	







M-536

72 00407

BALTIMORE CITY HEALTH DEPARTMENT

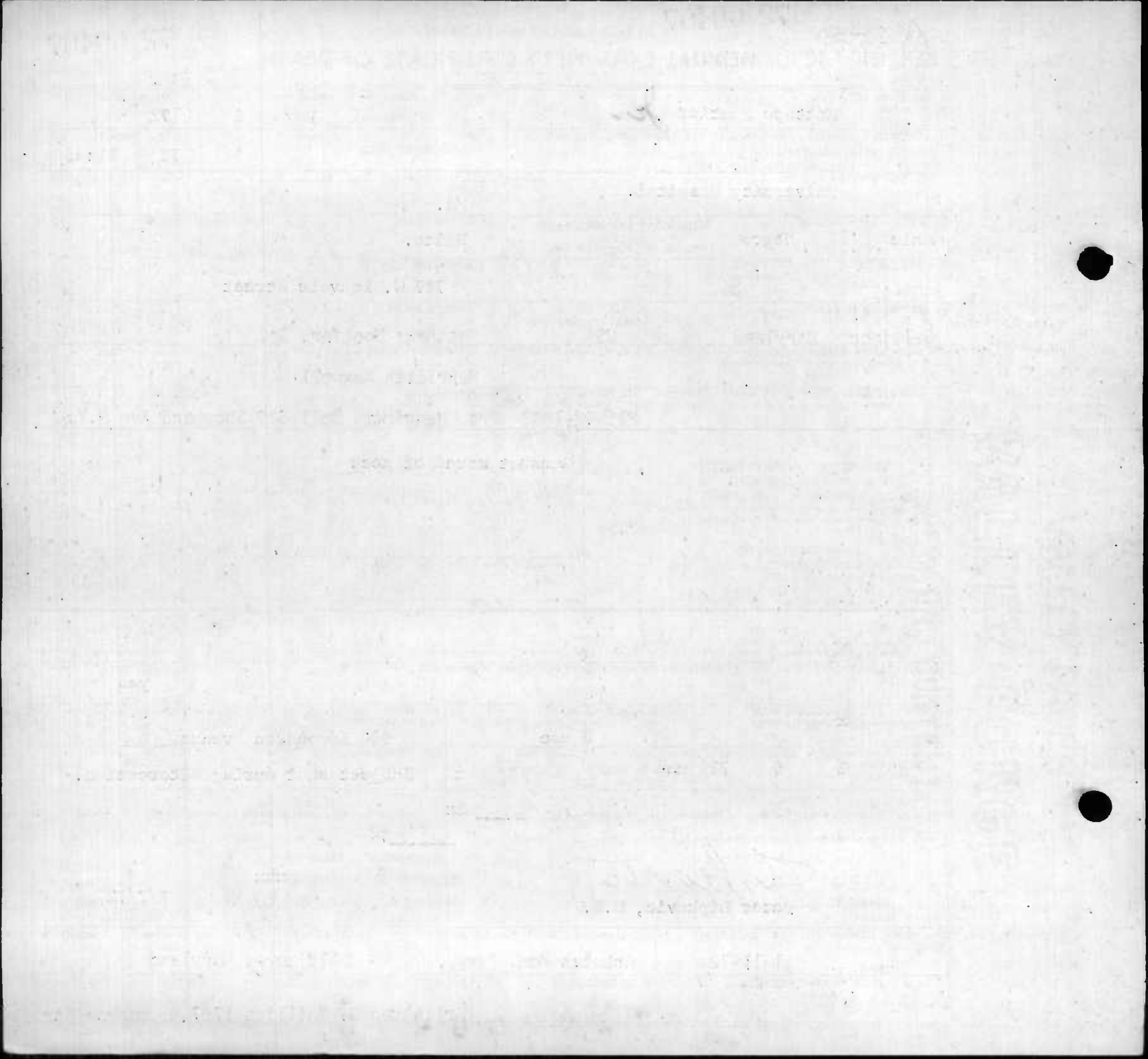
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00407

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Matthew Montier Jr.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 6 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 6 72 11:45 P.M.</b>			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1703</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>717 W. Lanvale Street</b>			
9. DATE OF BIRTH <b>2-20-45</b>		10. AGE (In years last birthday) <b>26</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Matthews Montier, Sr.</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Henrietta Maxwell</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>216-42-1848</b>		18. INFORMANT ADDRESS <b>Mrs. Henrietta Bell 528 Shephard Ave N.Y.</b>			
19. <b>E 965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH <b>Gunshot wound of neck</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>900 Edmondson Avenue 1601</b>			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1 6 72 unk</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot during altercation.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic</b> M.D. EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>1/7/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-11-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>James S. Phillips</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Arlington S. Phillips 1727 N. Monroe Street</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-000 72 00408		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00408	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WILLIE D. LEE</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 9/72 7:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21215 2798</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>PROVIDENT HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
39		E. STREET AND NUMBER <b>3500 WOODLAWN AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-08</b>	9. AGE (In years last birthday) <b>63</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Board</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Dawson Lee</b>		14. MOTHER'S MAIDEN NAME <b>Willie A. Hammond</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>242-05-7589</b>		17. INFORMANT <b>Nora B. Lee</b> ADDRESS <b>Same</b>	
18. <b>162.1 I 242-05-7589</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Advance carcinoma of the lungs</b>		<b>11 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>Feb 1974</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Lungs</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 7 1972</b> to <b>Jan 9 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 9 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose M. Hipolito</b>				23B. DATE SIGNED <b>9 Jan 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE M. HIPOBITO</b>		23D. ADDRESS <b>Provident Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removed 1-13-72</b>		24B. DATE <b>1-13-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baker</b>	
24D. LOCATION <b>Slymouth</b>		24E. (City, town, or county) (State) <b>N.C.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>P. E. E. 722 0</b>		25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b> ADDRESS <b>1727 W. Mount St.</b>	

2.

12  
North Carolina  
Wm. B. Thompson  
Secretary of the  
Board of  
Education

Remond 1-13-75 Baker  
Thompson  
N.C.  
North Carolina

1. NAME OF DECEASED (Type or Print) <b>JAMES F. QUILLE Jr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 626 W. Lanvale St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 9 1972 2:30p</b> M.	
6. SEX <b>male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>4-27-16</b>		10. AGE (In years last birthday) <b>55</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lercy Quille</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1402</b>	
15. MOTHER'S MAIDEN NAME <b>Etta Brown</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W41 II</b>		17. SOCIAL SECURITY NO. <b>212-03-0408</b>	
18. INFORMANT <b>James Quille Jr.</b>		ADDRESS <b>1801 Whitman Ave.</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>1-10-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-13-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>A.A.G. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wright &amp; Phillips</b>		ADDRESS <b>1727 N. Mount St.</b>	





A-450

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00410

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES ALLEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1002 N. Bond St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 9 1972 3:25 p.m.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 29, 1925</b>		10. AGE (In years last birthday) <b>45</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Golden Allen</b>		14. MOTHER'S MAIDEN NAME <b>Mame Walden</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Golden Allen</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-10-72</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>1-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Nottingham</b>	
24D. LOCATION (City, town, or county) (State) <b>Cal County</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>St. Johns</b>	
25D. ADDRESS <b>1001 Broadway</b>			

2-3-1972 - Form - Completion of cause of death on a pending medical examiner death certificate

Russell S. Fisher, M.D.

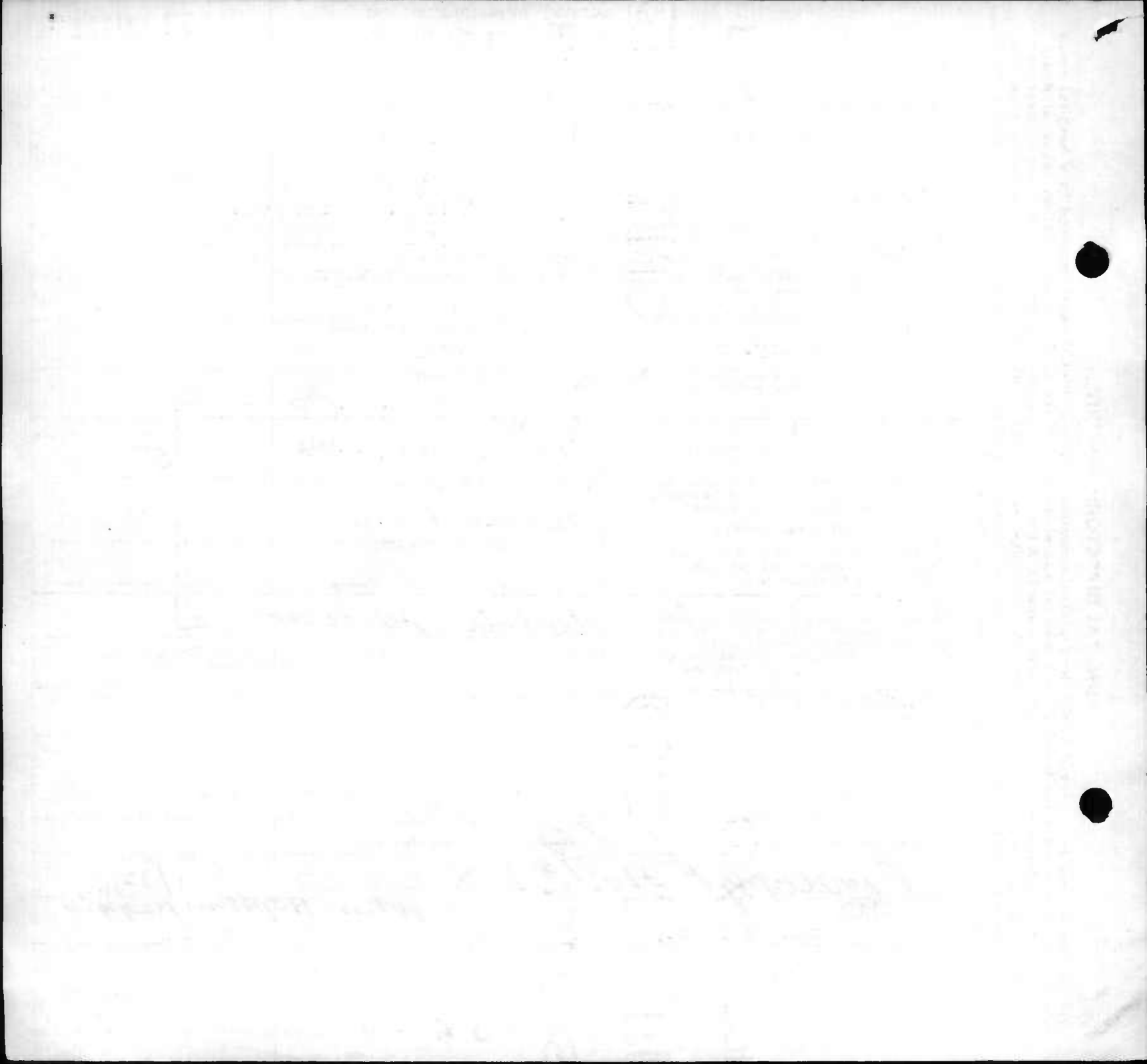
HRS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00411	
A-536 72 00411 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Anderson Daisy</i>		2. DATE AND HOUR OF DEATH <i>Jan. 12, 72 11:10 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>833</i>			
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11/22/12</i>		9. AGE (In years (last birthday)) <i>59</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Anderson Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>412.31x250.9</i> <b>CARDIAC ARRHYTHMIA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>SEVERE ASCVD</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>diabetes, previous m.i.'s</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min's</i> <i>2 yrs.</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>72</i> to <i>1/12</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1/12</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Penelope A. Scott MD</i>				23B. DATE SIGNED <i>1/12/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Penelope Scott, MD</i>				23D. ADDRESS <i>The Johns Hopkins Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-17-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cmt.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 14 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor R.D.</i>		25C. FUNERAL DIRECTOR <i>Equinox 1000 Brewster</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) COLYN ROZWELL or Razwill		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 7203 Moyer AVE		3. DATE PRONOUNCED DEAD Month Day Year Hour January 12, 1972 9:45 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH July 28 1884		10. AGE (In years last birthday) 87	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor		14B. KIND OF BUSINESS OR INDUSTRY Clothing	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-18-2389	
18. INFORMANT Mary H. Razwill		ADDRESS 7203 Moyer Avenue 21234	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 15 1972	
24C. NAME OF CEMETERY or CREMATORY Holy Trinity Cemetery		24D. LOCATION (City, town, or county) (State) Elkridge Howard Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR The Dippel Bros Inc		ADDRESS 7110 Belair Road	

RECEIVED TO THE DIRECTOR

1944, 11/11/44

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>IDELLA WHITTINGTON KNOX</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3028 W. Garrison Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>1 10 1972 5 a</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Oct. 14, 1941</b>		10. AGE (In years lost birthday) <b>35</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Arneeda Giles</b>		18. INFORMANT ADDRESS <b>Thomas L Knox, 3028 Garrison Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1.14.72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kenneth Law</b>		ADDRESS <b>4611 Park Heights Ave</b>	

BY AGENT

CHIEF

of I. I. I.

XXXX

I. I. I.

BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 72 00411

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Dewayne GIBSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 12, 1972 10:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>8 UNIVERSITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour January 12, 1972 10:45 A.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1-28-55</b>		10. AGE (In years lost birthday) <b>16</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anderson Smith</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1604</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Gloria Gibson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Gloria Gibson</b>	
19. <b>304.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Gunshot wound of spine with paraplegia</b>		CAUSE OF DEATH <b>Cerebral anoxia complicating over-dose of drugs</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Narcotics addiction</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>1/13/72</b>	
24A. BURIAL CREMATION, REMOVAL, ETC. <b>Burial</b>		24B. DATE <b>1-17-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Ronald N. Kornblum</b>	
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>		25D. ADDRESS <b>1348 Calhoun Street</b>	



2-7-1972 - Completion of cause of death on a pending medical examiner death certificate  
Ronald N. Kornblum, M.D.

HRS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNIE SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 12, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 947 S. Sharp Street		3. DATE PRONOUNCED DEAD Month Day Year January 12, 1972		Hour M. 2:45 P.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-12-04		10. AGE (in years last birthday) 67		11. BIRTHPLACE (State or foreign country) Calvert Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Young		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser	
15. MOTHER'S MAIDEN NAME Carrie Gray		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -----		17. SOCIAL SECURITY NO. 212-09-2852	
18. INFORMANT Alice Clark		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION 21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> January 13, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-15-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972		25B. NAME OF REGISTRAR V.R. Bailey	
25C. FUNERAL DIRECTOR Nelson F. H.		25D. ADDRESS 1348 N. Calhoun St.			

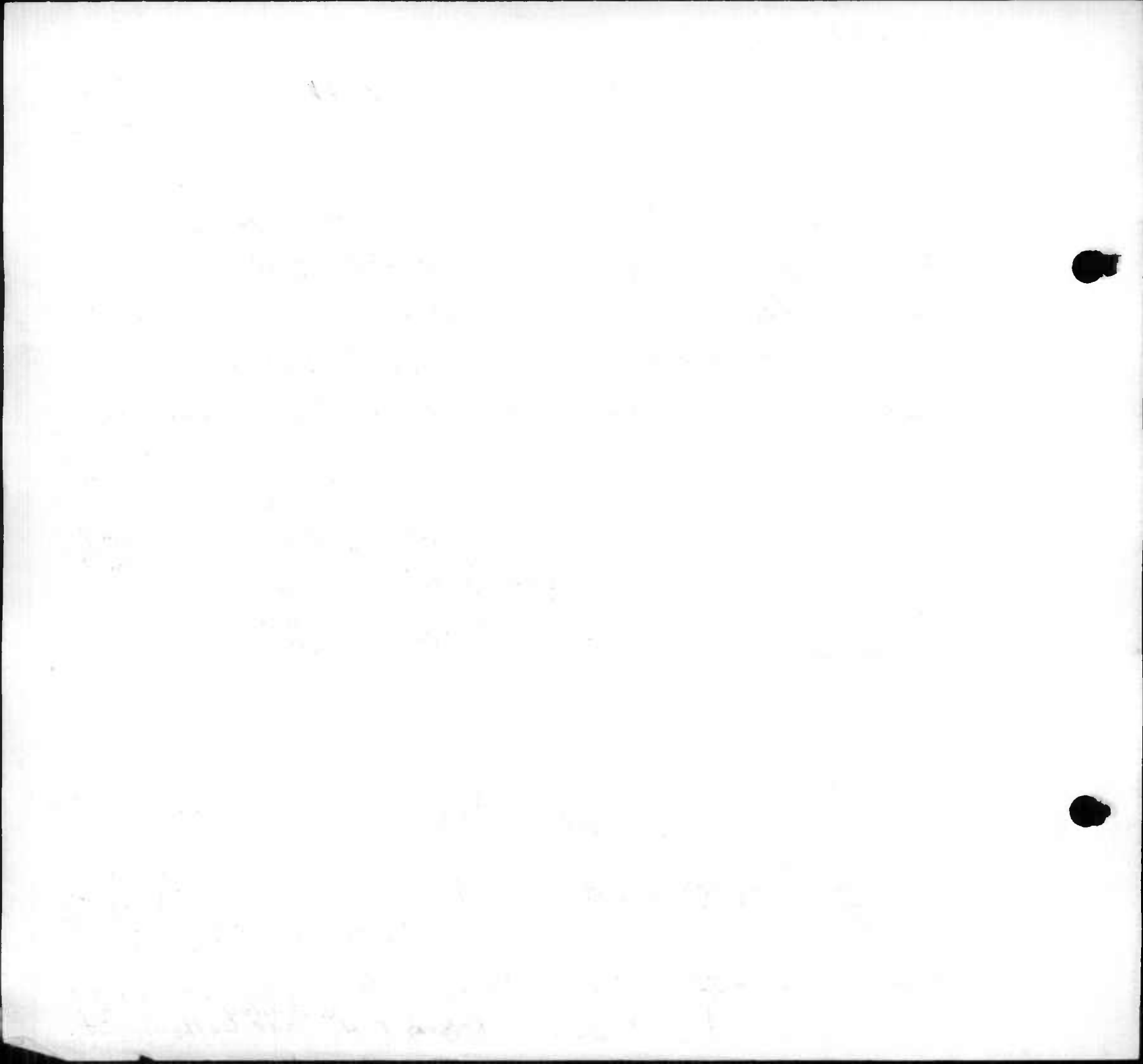
1972

ACADEMY RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00416</u>	
<b>BIRTH NO.</b> <u>N-620</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>1-13-72</u> <u>6:40pm</u> M.			
<b>1. NAME OF DECEASED</b> (Type or Print) <u>Ida Norris</u>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Mt. Sinai N. H.</u>			
<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2755</u>		<b>5. CITY OR TOWN</b> <u>Balto.</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>6. STREET AND NUMBER</b> <u>2009 Kelly Ave</u>		<b>7. SEX</b> <u>F</u> <b>8. RACE</b> <u>Negroid</u> <b>9. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Albert Norris</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Louisa Johnson</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-68-4985</u>		<b>17. INFORMANT</b> <u>Elsie Smith</u> <b>ADDRESS</b> <u>Same</u>	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>(A) IMMEDIATE CAUSE</b> <u>Myocardial infarction</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B)</b> <u>Cronary artery disease</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b> <u>Arteriosclerosis</u>	
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Chronic renal disease, hypertension</u>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>1/13</u> <b>19</b> <u>72</u> <b>to</b> <u>1/11</u> <b>19</b> <u>72</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/11</u> <b>19</b> <u>72</u> <b>and that (I) (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Stanley D. Madison MD</u>				<b>23B. DATE SIGNED</b> <u>1/13/72</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>STANLEY D MADISON MD</u>				<b>23D. ADDRESS</b> <u>2444 E. Belknap St. Baltimore</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>1- - 72</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Church Cem.</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Northumberland, Va.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 14 1972</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> <u>V. Bailey</u> <b>ADDRESS</b> <u>1348 Calhoun St.</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72-00417

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES BROWN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 9 1972 10:37a</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1502</b>	
9. DATE OF BIRTH <b>1-18-1890</b>		10. AGE (In years last birthday) <b>81</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Brown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>gardner</b>	
15. MOTHER'S MAIDEN NAME <b>Anna Brown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes World War 1</b>	
17. SOCIAL SECURITY NO. <b>214-14-1620</b>		18. INFORMANT ADDRESS <b>Mrs. Ruth Neal 2130 N. Pulaski Street</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-10-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>Gettysburg National cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Gettysburg Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>3610 1-17-72-240</b>	
25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AVE</b>	

NO. 100-100000  
JAN 10 1972

JOHN W. DODD, JR.

1-10-1972

100000

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JOHN W. DODD, JR.

1-10-1972

JOHN W. DODD, JR.

JOHN W. DODD, JR.

1-10-1972

JOHN W. DODD, JR.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 357143 HA	
CERTIFICATE OF DEATH					
BIRTH NO. 250 72 00418		1. NAME OF DECEASED (Type or Print) JACKSON, Mr. Meredith A.			
2. DATE AND HOUR OF DEATH 1-12-72 5 <sup>30</sup> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 8 MGH		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1504	
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/22/13		9. AGE (in years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Regger	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andrew Jackson	
14. MOTHER'S MAIDEN NAME Anita Harden		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-29-26	
17. INFORMANT Anne Mae Jackson		ADDRESS 2418 Reisterstown Rd.			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca ? primary - liver			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1-6-1972 to 1-12-1972 that (1) (we) last saw the deceased alive on 1-12-1972 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manjivani		23B. DATE SIGNED 1-12-72		23C. PHYSICIAN'S NAME (Type) MANJIVANI	
23D. ADDRESS MGH 127-2nd ave		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-72		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore Co., Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 14 1972			
24F. NAME OF REGISTRAR		24G. FUNERAL DIRECTOR		24H. ADDRESS	
24I. FUNERAL HOME 3035 W. NORTH AVE.					

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B-650

72 00419

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00419

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN HENRY BROWN

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

January 13, 1972

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00

3601 Edgewood Road

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 13, 1972

11:35 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

15-11

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11-12-1871

10. AGE (In years  
last birthday)

100

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3601 Edgewood Road

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacob Brown

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Fannie ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-10-5202

18. INFORMANT

ADDRESS

Mrs. Margaret Holliday 3601 Edgewood Rd

19.

412.4 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED,  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Charles S. Springate  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 13, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-18-1972

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 14 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

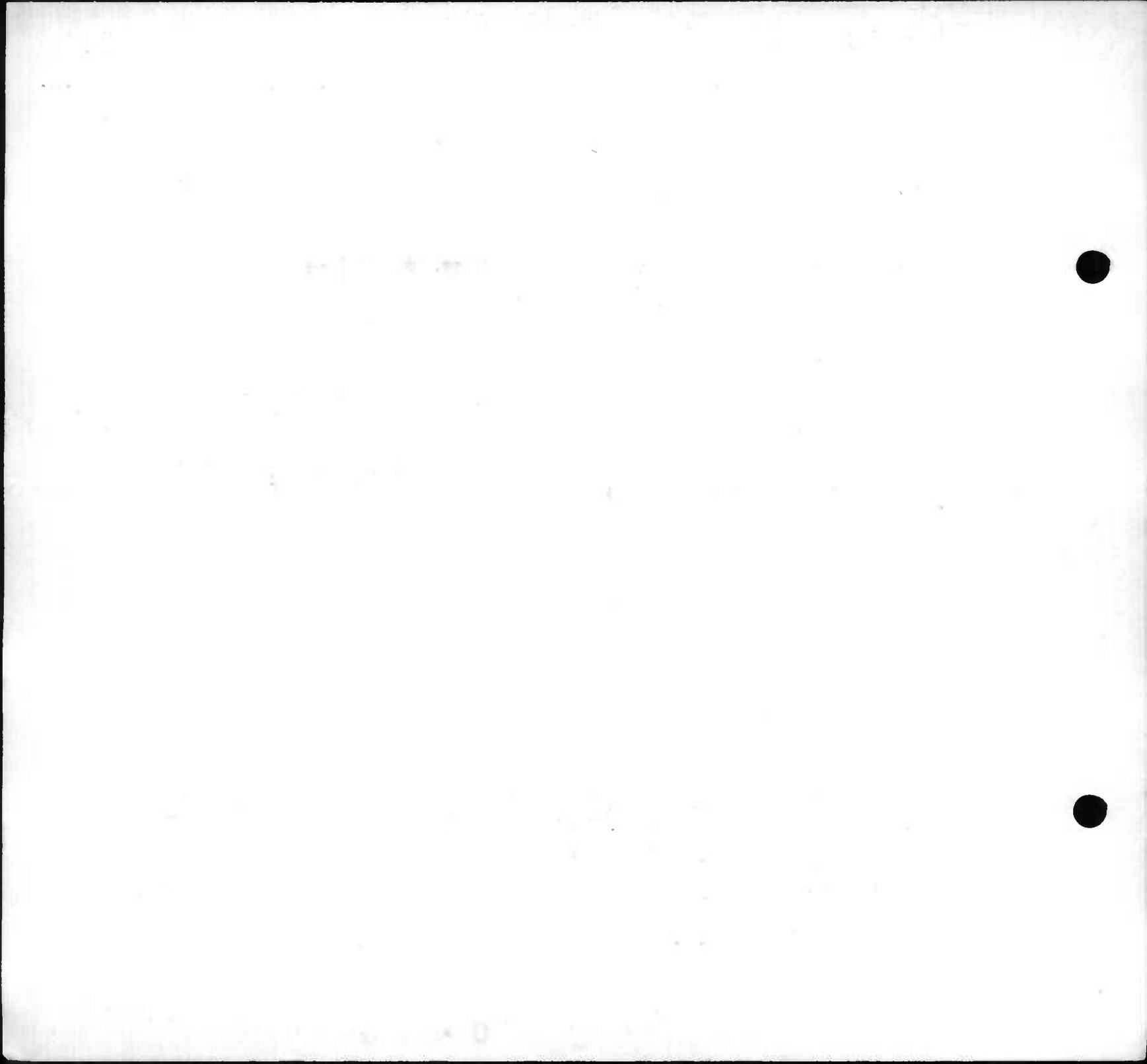
Nutter Funeral Home 3035 W. NORTH AV

ACADEMY & BOOK

WILLY & PIERRE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

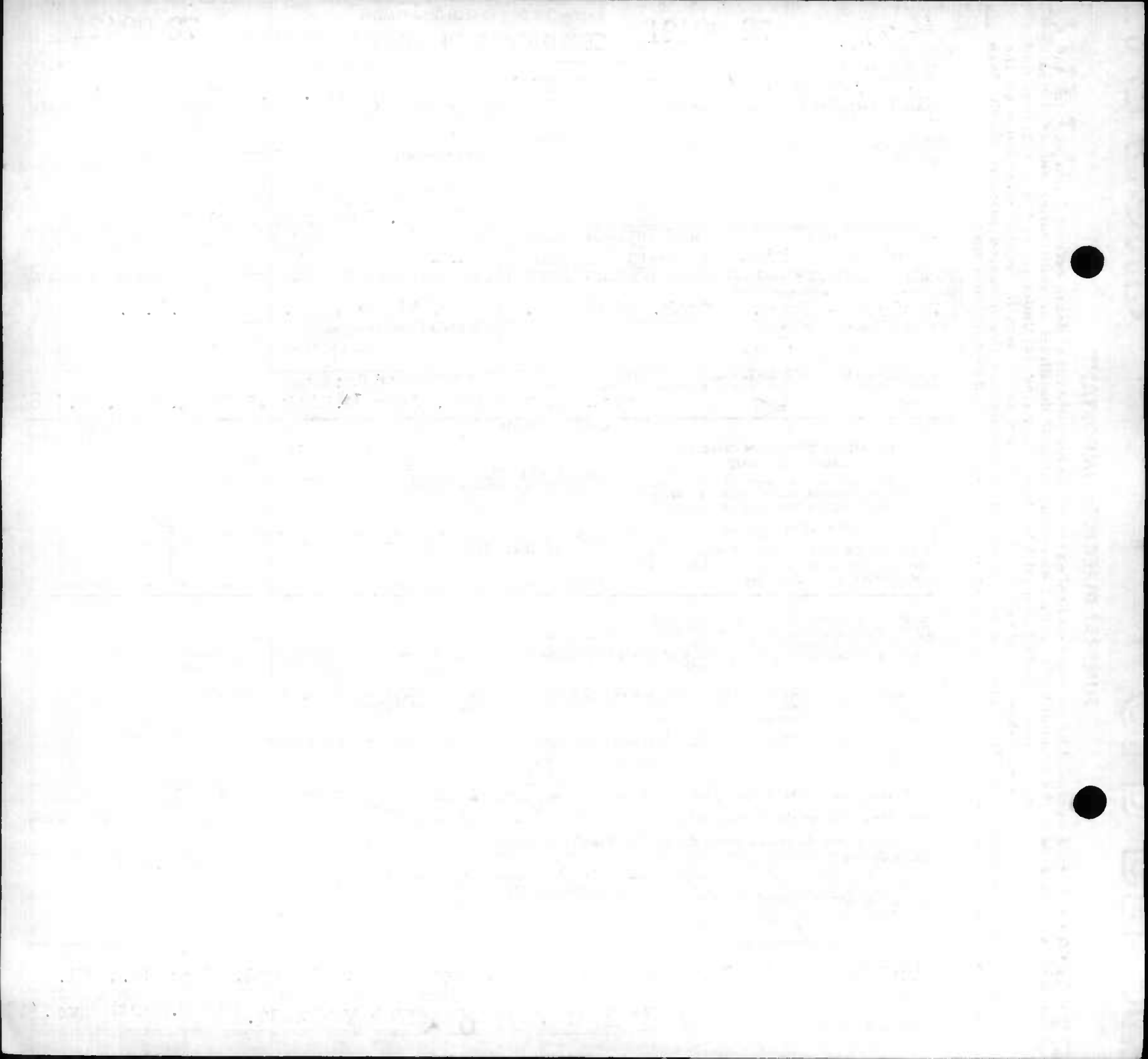
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00420</u>	
M-000 72 00420				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William Mayo</u>		2. DATE AND HOUR OF DEATH <u>Jan. 13, 1972</u> <u>5:50 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1703</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>832 Harlem Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-95</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Littleton, N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Thomas T. Mayo</u>		
14. MOTHER'S MAIDEN NAME <u>Lena</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>216-07-4935</u>			17. INFORMANT <u>Rev. Wm. Mayo 1721 Gwynns Falls Pkwy.</u> <u>Mr. Albert M. Mayo 2015 E. Chase St. 21213</u> <u>Mr. Milton A. Mayo 209 N. Pulaski St. 21223</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of stomach</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1519 I</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>12/15/71</u> 19 <u>71</u> to <u>1/13/72</u> 19 <u>72</u> that <u>X</u> (we) last saw the deceased alive on <u>Jan. 12</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Michael Colvin</u>				23B. DATE SIGNED <u>1/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael Colvin, M.D.</u>				23D. ADDRESS <u>Good Samaritan Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-16-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION <u>A.A. Co., Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>			
24F. NAME OF REGISTRAR <u>Robert E. Jones, Jr.</u>		24G. FUNERAL DIRECTOR <u>Marshall V. Jones, Jr.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00421</u>	
4-200 72 00421				CERTIFICATE OF DEATH	
BIRTH NO. <u>4-200</u>		1. NAME OF DECEASED (Type or Print) <u>John Hisky (JOHN GUIDO HISKY)</u>		2. DATE AND HOUR OF DEATH <u>Jan. 11, 1972</u> <u>5:15 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>37 MERCY HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1201</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3900 N. Charles St</u> <u>21218</u>		
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-98</u>		9. AGE (in years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Exec.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Foley Thomas/Hisky</u>		
14. MOTHER'S MAIDEN NAME <u>Hannah McClelland</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWI Yes WWI</u>		
16. SOCIAL SECURITY NO. <u>213-18-1707</u>			17. INFORMANT <u>Wife:</u> ADDRESS <u>Mrs. John G. Hisky, 3900 N. Chas. St. (18)</u>		
18. <u>4-10-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Vent. Fibrillation</u> (B) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1-6</u> 19 <u>72</u> to <u>1-11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael F. Plott, M.D.</u>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL F. PLOTT M.D.</u>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/14/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Still Pond Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Still Pond, Kent Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 14 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>STEWART &amp; MOWEN CO.</u>			
25D. ADDRESS <u>108 W. North Ave. (1)</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00422</b>	
P-126 <b>72 00422</b>				CERTIFICATE OF DEATH	
BIRTH NO. <b>P-126</b>		1. NAME OF DECEASED <b>PAPA GEORGIU, ANASTASIA</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 10, 1972 1:35 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <b>40</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1903</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/12/87</b>		9. AGE (In years last birthday) <b>84</b>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>GREECE</b>		13. FATHER'S NAME <b>VAGIONO VAGIONU</b>		14. MOTHER'S MAIDEN NAME <b>(HATZIKOLU) DESPINA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CUA - cerebral vascular accident -</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>A.S.C.V.D -</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 8, 1972</b> to <b>JANUARY 10, 1972</b> that (X) (we) last saw the deceased alive on <b>JANUARY 10, 1972</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE <b>Sergio San Pedro</b>		23B. DATE SIGNED <b>01-10-72</b>		23C. PHYSICIAN'S NAME (Type) <b>SERGIO SAN PEDRO, M.D.</b>	
23D. ADDRESS <b>BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-12-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Greek Orthodox Cemetery</b>		24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>	
25A. NAME OF REGISTRAR <b>Nicholas T. Matthews</b>		25B. ADDRESS <b>6024 Eastern Ave., Baltimore, Md.</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>	



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72 00423

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00423

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Camper Laurence Lawrence Hooper</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>11</b> Year <b>72</b> Hour <b>12:50 P.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1124 Watson Street</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>11</b> Year <b>72</b> Hour <b>12:50 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12-28-1897</b>		10. AGE (In years lost birthday) <b>75 74</b>	
11. BIRTHPLACE (State or foreign country) <b>New Brunswick, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C Hooper</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>302</b>	
15. MOTHER'S MAIDEN NAME <b>Unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>John C. Hooper - 2923 Forest Glen Rd 21216</b>	
19. CAUSE OF DEATH <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1-14-1971</b> 24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b> 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b> 25C. FUNERAL DIRECTOR ADDRESS <b>Armarost Funeral Chapel - 4600 Liberty Ht.</b>			

35000 ST

35000 ST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
72 00424				72 00424	
BIRTH NO. <span style="font-size: 2em;">D-620</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ELIZABETH DORSEY</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JAN. 11, 1972</span> <span style="font-size: 1.2em;">9:30 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">841</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">H2 SINAI HOSPITAL OF BALTO.</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <span style="font-size: 1.2em;">3205 LAWNVIEW AVE. A13</span>			
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">CAUCASIAN</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8/4/03</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">68</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">State N/A</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">ANNAPOLIS, MARYLAND U.S.A.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">WILLIAM J. SAUNDERS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CATHERINE DOROUGHTY</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">[REDACTED]</span>		17. INFORMANT <span style="font-size: 1.2em;">PATIENT'S MEDICAL CHART</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">SPINDLE CELL CA OF THYROID</span>		CAUSE OF DEATH <span style="font-size: 1.2em;">E DISTANT METASTASIS</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">LEUKOPENIA, ANEMIA, PRUG INJECTED</span>		(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CAPRO RESPIRATORY ARREST</span>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/30</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">1/11</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/11/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CAYETANO J. PIZON, M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTO.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">JAN. 14/1972</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">ST ANN'S Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">ANNAPOLIS, MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 14 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">[Signature]</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">[Signature]</span>		25D. ADDRESS <span style="font-size: 1.2em;">[Signature]</span>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-120		72 00425		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 00425	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LIPPS, CARVILLA Helfrich</b>				2. DATE AND HOUR OF DEATH <b>Jan 11 1972 6<sup>30</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Union Memorial Hospital</b>						A. STATE <b>MD</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33rd &amp; Calvert St. Baltimore</b>						B. COUNTY <b>Catonsville</b>			
						C. CITY OR TOWN <b>Catonsville</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER <b>102 Delrey Avenue 5300</b>			
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>06-07-04</b>		9. AGE (in years last birthday) <b>67</b>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate Agent</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland-Arbutus</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Samuel H. Helfrich</b>					14. MOTHER'S MAIDEN NAME <b>Bryant Edith E. Benson</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Frank B. Lipps-102 Delrey Ave.-21228</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Colon Cancer</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>June 1971</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Miles Resection</b>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 12 1971</b> to <b>Jan 11 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 11 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Teh-ching Wang MD</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Jan 11 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>TEH-CHING WANG</b>						23D. ADDRESS <b>3122 Guilford Ave. Baltimore MD 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/14/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>			25C. FUNERAL DIRECTOR ADDRESS <b>736 Edmondson Ave. Catonsville, Md 21043</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-310		72 00426		CERTIFICATE OF DEATH		REG. NO. 72 00426	
1. NAME OF DECEASED (Type or Print) <b>VAIDIVIA, AURELIO</b>				2. DATE AND HOUR OF DEATH <b>1-11-72 2:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1307</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>812 W. 37TH STREET.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-1904</b>	9. AGE (In years last birthday) <b>67</b>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>VAIDIVIA ONERIO</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-9229</b>		17. INFORMANT ADDRESS <b>Gladys Valdivia 812 W. 37th St. 21211</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>CARDIAC ARREST</b> <b>Bilateral PNEUMONIA</b> <b>C. O. A. D.</b> <b>CONGESTIVE H. FAILURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>1-9-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-9-72</b> to <b>1-11-72</b> that (I) (we) last saw the deceased alive on <b>1-11-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carlos A. Battilana MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-11-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Carlos A. Battilana MD</b>		23D. ADDRESS <b>UNION MEMORIAL HOSP.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan 14, '72</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>John J. Taylor</b>		25C. FUNERAL DIRECTOR <b>John J. Taylor</b>		ADDRESS <b>3618 Roland Ave 21211</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00427</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 00427</span>	
1. NAME OF DECEASED (Type or Print) <b>VIOLET M. KRAEMER</b>			2. DATE AND HOUR OF DEATH <b>1/10/ 72</b> <span style="float: right;">10 A. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 316 Gittings Avenue</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2712</b> C. CITY OR TOWN <b>Baltimore City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>316 Gittings Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1880</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <b>Brooklyn N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jacob Simonson</b>			14. MOTHER'S MAIDEN NAME <b>Mary Simonson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Mr. Peter Kraemer</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?  22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1961</b> to <b>Jan 10 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 9 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Frederick J. Vollmer M.D.</b> 23B. DATE SIGNED <b>1-12-72</b> 23C. PHYSICIAN'S NAME (Type) <b>Frederick Vollmer M.D.</b> 23D. ADDRESS  24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1/13/72</b> 24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Balto. Co</b> 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b> 25B. NAME OF REGISTRAR <b>Robert E. Taber, R.D.</b> 25C. FUNERAL DIRECTOR <b>Mitchell Niefeld</b> ADDRESS <b>Home-6500 York Rd. 21212</b>					

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00428

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EUNICE WATERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 35 N. Monastery Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 9 1972 3 p M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Oct 7, 1920</b>		10. AGE (In years last birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James E. Wallace</b>		14. MOTHER'S MAIDEN NAME <b>Maud L. Thomas</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <b>219-30-6500</b>	
19. CAUSE OF DEATH <b>450X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Massive pulmonary embolism</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. DUE TO, OR AS A CONSEQUENCE OF:	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. DUE TO, OR AS A CONSEQUENCE OF:	
25. DATE OF OPERATION <b>2</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. AUTOPSY? (Yes or No) <b>yes</b>			
28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
31. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
33. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-10-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/14/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arboretum Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph E. Rocco</b>		ADDRESS <b>2222 W. North Ave.</b>	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00429

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Leslie Wittaker</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 14 72</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF ADDRESS OR INSTITUTION <b>1348 W. North Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 14 72 6:15 a.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7/20/25</b>		10. AGE (In years last birthday) <b>46</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Marshall Whitaker</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1303</b>	
15. MOTHER'S MAIDEN NAME <b>Minnie Culpepper</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 2</b>	
17. SOCIAL SECURITY NO. <b>264-24-2414</b>		18. INFORMANT ADDRESS <b>Mrs Thelma Gray, 4209 Pimlico Rd</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME (Month) (Day) (Year) (Hour) (Approx.)		27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29. HOW DID INJURY OCCUR?	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1/14/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

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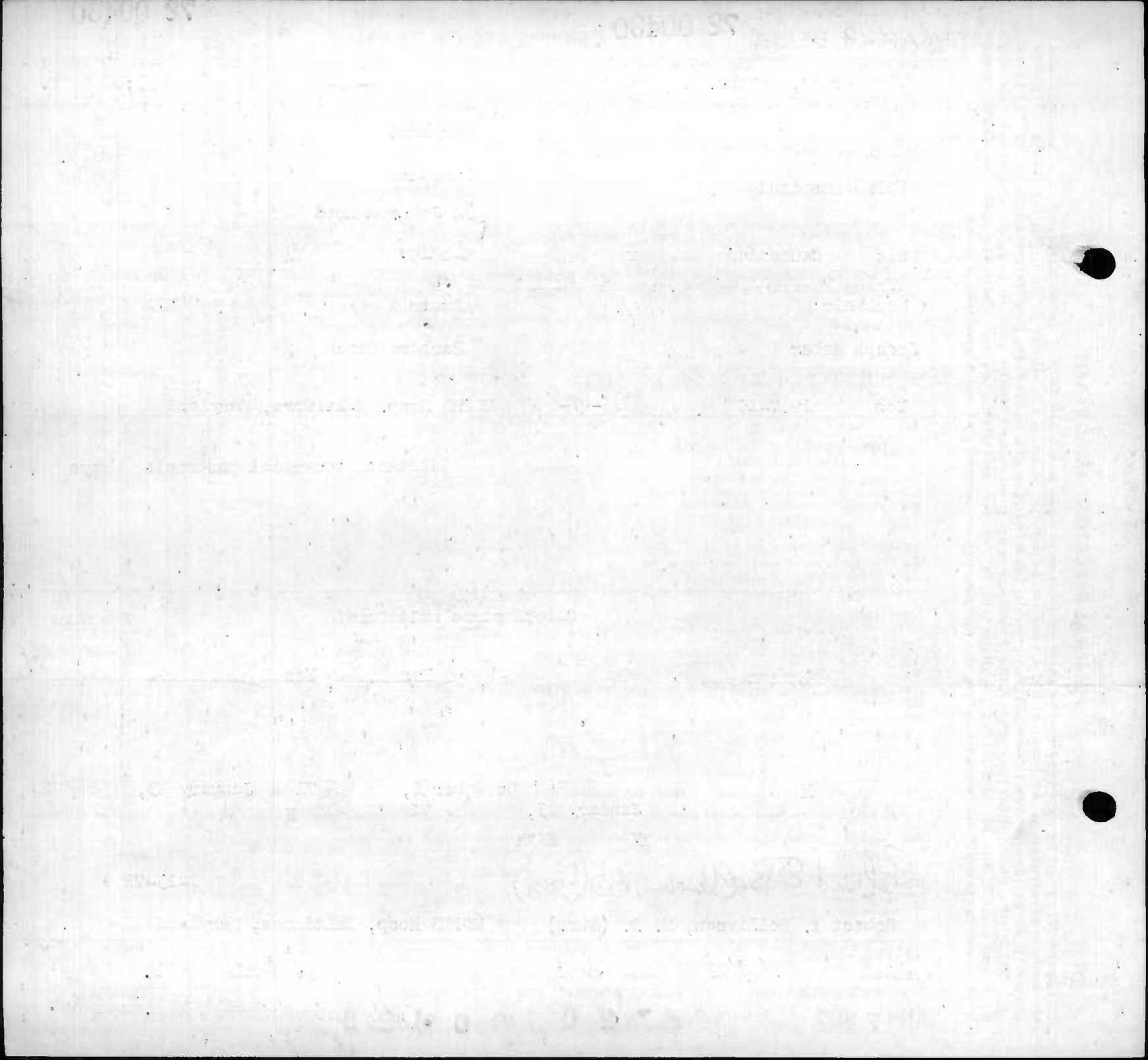
*[Faint, illegible handwritten text]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-160		72 00430		72 00430	
1. NAME OF DECEASED (Type or Print) Weber, Matthew			2. DATE AND HOUR OF DEATH 1-13-72 3:00 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) USPHS Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 34 Johnson Road		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-97	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME Joseph Weber			14. MOTHER'S MAIDEN NAME Barbara Besch		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1917-19		16. SOCIAL SECURITY NO. 215-01-6371		17. INFORMANT USPHS Hosp. Baltimore, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 485 XI + 192.9 CAUSE OF DEATH (A) IMMEDIATE CAUSE Bilateral bronchial pneumonia days DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Glioblastoma multiformi			7 months		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from December 2, 19 71 to January 13, 19 72, that (X) (we) last saw the deceased alive on January 13, 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Belliveau, M.D. (Surg)				23B. DATE SIGNED 1-13-72	
23C. PHYSICIAN'S NAME (Type) Robert E. Belliveau, M. D. (Surg)		23D. ADDRESS USPHS Hosp, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/72		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Glen Burnie Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972			
25B. NAME OF REGISTRAR Robert E. Belliveau		25C. FUNERAL DIRECTOR M. J. Cuddy Funeral Homes 130 E. Fort Ave.			







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00431</b>	
S-652 72 00431				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>STEPHANIE J. SHRAMEK</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 11-1972 6:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2743</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3309 RUECKERT AVENUE</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1904 12-26-XX</b>		9. AGE (In years last birthday) <b>67 XX</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles J. Shramek</b>		14. MOTHER'S MAIDEN NAME <b>Sophia J. Ryba</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-9478</b>		17. INFORMANT ADDRESS <b>Mr. Frank Shramek, 713 Stonleigh Rd. 21212</b>	
18. CAUSE OF DEATH <b>4327 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY ARRES</b>					
(B) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF:					
(C) ARTERIO-SCLEROSIS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/30/71</b> to <b>1/11/72</b> that (I) (we) lost saw the deceased alive on <b>1/11/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>1/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGE VILLARON M.D.</b>		23D. ADDRESS <b>33rd and Calvert</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore County, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <b>72 00432</b>
<b>72 00432 CERTIFICATE OF DEATH</b>						
BIRTH NO.						
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH A. MATHERT</b>			2. DATE AND HOUR OF DEATH <b>1/12/72 1355 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2714</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HOUSE IN THE PINES BELVEDERE</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>OCT. 13, 1888</b> 9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>GRIFFIN</b>			
14. MOTHER'S MAIDEN NAME <b>SALLY ANN WALKER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>223-16-2104</b>			17. INFORMANT <b>AULSEY L. ROWE</b> ADDRESS <b>SAME AS #13E</b>			
18. CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Psy-chosis</b> <b>antw-reluctance</b>						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Capum left foot</b>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 15 19 72</b> to <b>Jan 12 1972</b> , that (I) (we) last saw the deceased alive on <b>Jan 12 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <b>Cherish / Oliver</b>				23B. DATE SIGNED <b>1/12/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. Lester Kolman</b>				23D. ADDRESS <b>DEGREE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-15-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		
24D. LOCATION <b>PARKVILLE</b>		24E. (City, town, or county) <b>MD.</b>		24F. (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>W. C. G. 220 0 0</b>		25C. FUNERAL DIRECTOR <b>Om Cook - Brooks Towson, Inc.</b>		
25D. ADDRESS <b>Towson, Md.</b>						

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00433

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VINCENT SVERCAVSKI		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1127 E. Baltimore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 5, 1972 9:10 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 302	
9. DATE OF BIRTH unknown		10. AGE (In years last birthday) 53 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. STREET AND NUMBER 1127 E. Baltimore Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) helper		14B. KIND OF BUSINESS OR INDUSTRY St. Vincent DePaul	
15. MOTHER'S MAIDEN NAME unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 137-26-9523		18. INFORMANT James Libertini Cathedral & Mulberry	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-13-72	
24C. NAME OF CEMETERY or CREMATORY SACRED HEART		24D. LOCATION (City, town, or county) (State) 7401 GERMAN Hill Rd Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR E. J. ...	
25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME		25D. ADDRESS 1216 S. CHARLES ST.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00434</b>	
<b>W-255 72 00434</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WAXMAN, LEO D</b>		1-13-72 4:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>27 40</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>5920 WINNER AVENUE #21215</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 15, 1901</b>
		9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHOP (PARISERS)</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB WAXMAN</b>		14. MOTHER'S MAIDEN NAME <b>MIRIAM</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>MRS. IDA WAXMAN, 5920 WINNER AVENUE #21215</b>	
		ADDRESS	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Anterior Myocardial Infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ventricular fibrillation</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b> (C) <b>Arteriosclerotic Heart Disease</b>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>1-13-1972</b> to <b>1-13-1972</b> that (I) (we) last saw the deceased alive on <b>1-13-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Rodolfo S. Vietorio M.D.</b>		23B. DATE SIGNED <b>1-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>RODOLFO S. VIEBRI M.D.</b>		23D. ADDRESS <b>Sinai Hospital of Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-14-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BNAI ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>SOL LEVINSON</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



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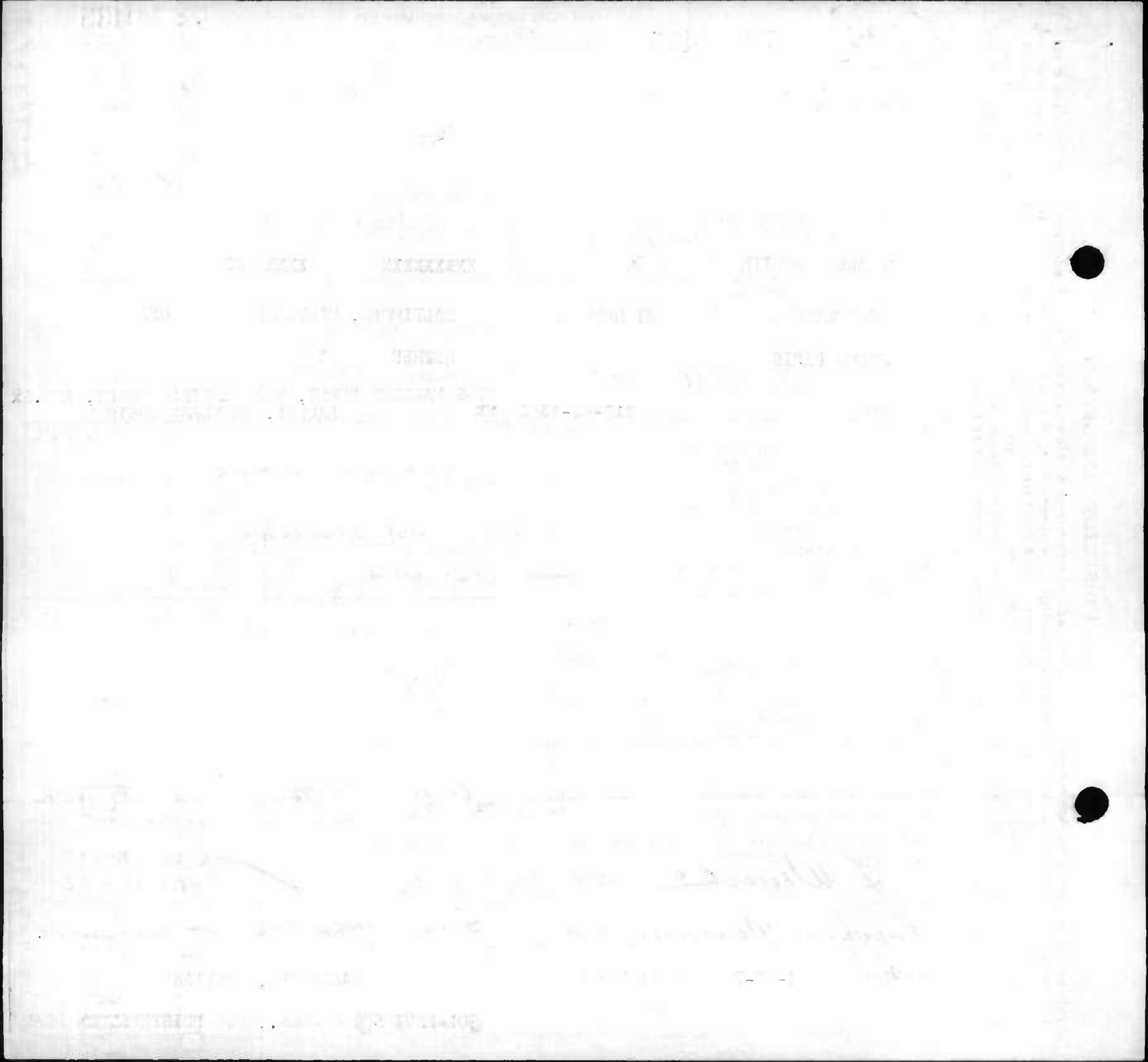
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00435		REG. NO.	
7-6,23				72 00435		72 00435	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>FURST, IDA</b>				2. DATE AND HOUR OF DEATH <b>1-11-72 3:15PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Emergency Room</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>2720</b>			
5. SEX <b>FEMALE</b>				6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		8. DATE OF BIRTH <b>XXXXXX</b> 9. AGE (in years last birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JACOB PARIS</b>				14. MOTHER'S MAIDEN NAME <b>ESTHER ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-62-1302</b>		17. INFORMANT <b>MISS MARLENE FURST, 8812 ENFIELD COURT, APT. 52 MR LAUREL, MARYLAND 20810</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>2-3-0-91</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS, CHF</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METABOLIC ACIDOSIS</b> (B) PROBABLE DUE TO, OR AS A CONSEQUENCE OF: <b>DBI INDUCED</b> (C) <b>NO UREMIA.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>&gt;</b> <b>YEARS</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-11-72</b> to <b>1-11-72</b> that (I) (we) last saw the deceased alive on <b>1-11-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Weinstein</b>				23B. DATE SIGNED <b>1-11-72</b>		23C. PHYSICIAN'S NAME (Type) <b>FRANKLIN WEINSTEIN MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>1-13-72</b>		24C. NAME of CEMETERY or CREMATORY <b>OHEL YAKOV</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>				25B. NAME OF REGISTRAR <b>GOLD LEVINSON</b>		25C. FUNERAL DIRECTOR <b>GOLD LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>				24E. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>G-656</b>      <b>72 00436</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p><b>72 00436</b></p> <p>REG. NO. _____</p>	
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>ANNA GRUENNER</b></p>		<p>2. DATE AND HOUR OF DEATH <b>1/15/72</b>      <b>7:15</b> P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MARYLAND 21205</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD MARYLAND</b> B. COUNTY _____ C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1160 QUANTRIL WAY</b></p>	
<p>5. SEX <b>FEMALE</b></p>	<p>6. RACE <b>WHITE</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>02/24/88</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY _____</p>	<p>9. AGE (In years last birthday) <b>83</b> If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____</p>
<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>George Gruenner</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>BARBARA Gruenner</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>215 14 7855</b></p>	<p>17. INFORMANT ADDRESS <b>Dorothy Wood 3010 McElderry Street</b></p>
<p>18. <b>157.9 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Arrest</b></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinomatous</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory Arrest</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinomatous</b></p> <p>(C) <b>Acute gastric perforation</b></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____</p>			
<p>19A. DATE OF OPERATION <b>12/22/71</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>acute gastric perforation</b></p>	
<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> 19 <b>71</b> to <b>1/15</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Genardy</b></p>		<p>23B. DATE SIGNED <b>1/15/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>RENE GENARDY M.D.</b></p>		<p>23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>1/18/72</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Washington Blvd. &amp; Dorsey Road</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Miller, M.D.</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Frederick D. Miller Inc</b></p>		<p>ADDRESS <b>3019 E. Monument Street</b></p>	

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72 00437

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00437

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH EDWARD REIS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>109 S. Arlington Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 10 1972 4:50 a.m.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1803</b>	
9. DATE OF BIRTH <b>11/30/53</b>		10. AGE (In years last birthday) <b>18</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank H. Reis</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>	
15. MOTHER'S MAIDEN NAME <b>Marie Yereb</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>217-56-1520</b>		18. INFORMANT ADDRESS <b>Mr. Frank Reis, 3 S. Kresson St. Balto. Md.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>304.1</b> <b>Chronic narcotism (subcutaneous-Dolophine) with associated chronic myocarditis and portal hepatitis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2/1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-10-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/13/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph N. Zannino</b>		ADDRESS <b>263 S. Conkling St.</b>	

2-14-1972 - Completion of cause of death on a pending medical examiner death certificate

Russell S. Fisher, M.D.

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		72 00438	
S455 72 00438		CERTIFICATE OF DEATH		72 00438	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Schluing Edith Bankhard		1-12-72 4-30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
NORTH Charles General Hospital 49		Md. BALTO 5300			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN			
NORTH Charles General Hospital		BALTO			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
MORE SALSADY		STREET CO.		11/14/17	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
JACKSON Bankhard (D)		Edith Crutchley (D)		54	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
NO		2B-10-5094		Md.	
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?			
Paul F. Schluing 1684 Yakona Rd.		USA			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		24 Days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES		Pneumonia, pulm embolism			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		EVA E L and her hemiplegic 14 Months			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
		Bad care all time 3 months			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
-		-		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
-		-		-	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
-		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-	
22. I certify that (I) (this hospital) attended the deceased from 12-29-1971 to 1-12-1972 that (I) (we) last saw the deceased alive on 1-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Veena Sathirakul M.D.		1-12-72		VEENA SATHIRAKUL M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-14-1972		Dulaney Valley Mem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 17 1972		Robert E. Taylor, M.D.		307 W North Ave	

2011 57

2011 57

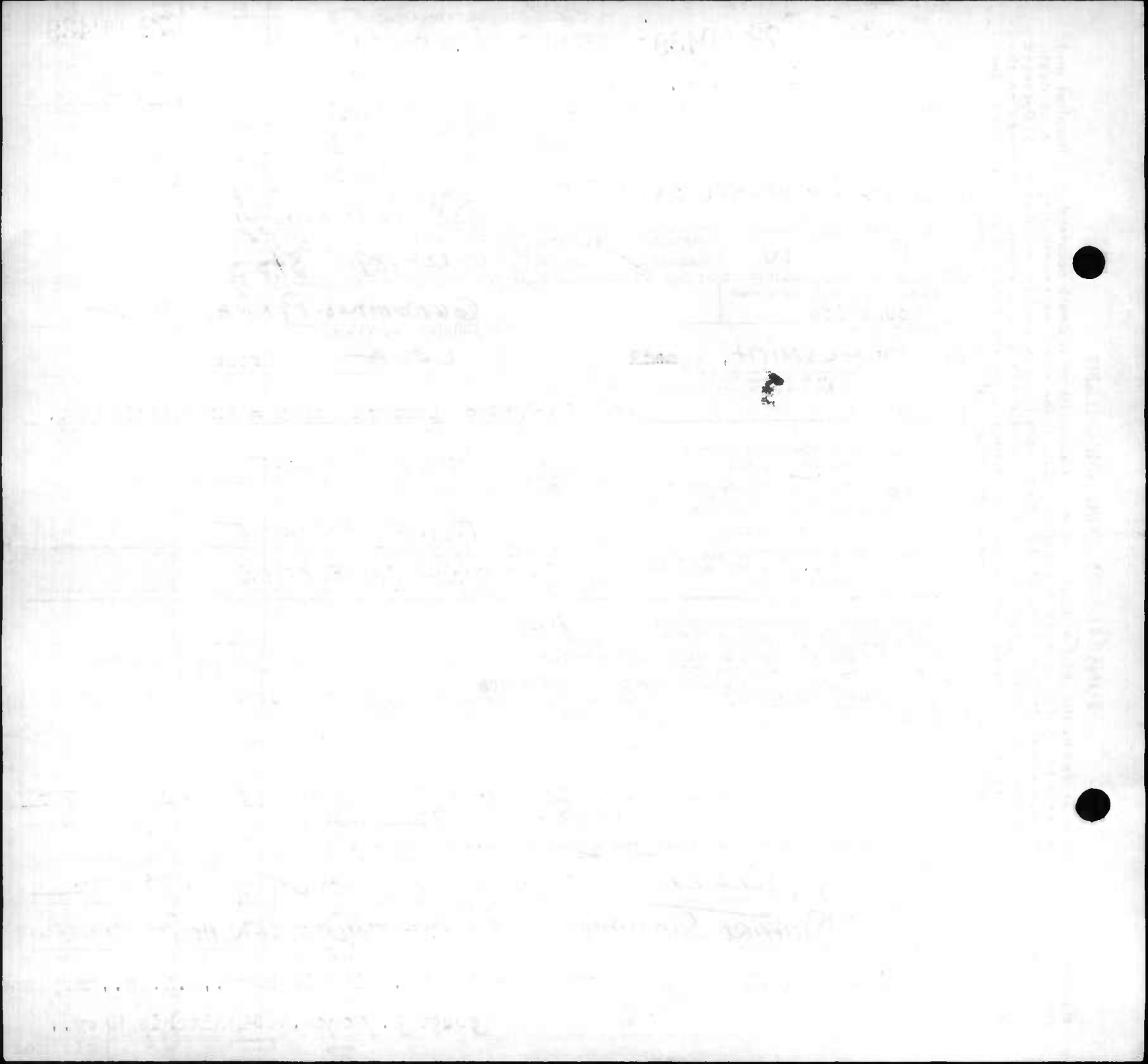




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
W-435		72 00439		72 00439	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ANNA C. WALTON			1/12-72 1 4 <sup>10</sup> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
43 South-BALTIMORE GEN. HOSP.			MARYLAND 2201		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			828. William St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-12-1890	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			GERMANY, PENNA.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
BLACKSMITH, Emil			LONA Gross		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			205-03-7782-B		B. Doranne Hardy = 828 William St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			HEART FAILURE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			RENAL FAILURE		
			(C) INTestinal Obstruction		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
AGE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1-7-72		INTestinal Obstruction			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-2-1972 to 1-12-1972 that (I) (we) lost saw the deceased alive on 1-12-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Richard SIAHAAN			1-12-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
RICHARD SIAHAAN			So. BALTIMORE GEN. HOSP. BALTO.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/13/72		Glen Haven Memorial Pk. Ritchie Hgwy., A.A.Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 17 1972		George J. Gonce		4001 Ritchie Hgwy., Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00440</span>	
<p><b>P-324</b> <span style="float: right;">72 00440</span></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>BIRTH NO. <span style="float: right;">72 00440</span></p>			
<p>1. NAME OF DECEASED (Type or Print) <b>Max John Patzold</b></p>			<p>2. DATE AND HOUR OF DEATH <b>January 13, 1972</b> <span style="float: right;">8: P. M.</span></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span></p> <p><b>00</b> <span style="float: right;"><b>2101 Woodbourne Ave</b></span></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <span style="float: right;">B. COUNTY</span></p> <p><b>Maryland</b> <span style="float: right;"><b>2706</b></span></p> <p>C. CITY OR TOWN <span style="float: right;">D. INSIDE CITY LIMITS?</span></p> <p><b>Baltimore</b> <span style="float: right;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span></p> <p>E. STREET AND NUMBER <span style="float: right;"><b>2101 Woodbourne Ave</b></span></p>		
<p>5. SEX <span style="float: right;">6. RACE</span></p> <p><b>Male</b> <span style="float: right;"><b>White</b></span></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <span style="float: right;">9. AGE (In years last birthday)</span></p> <p><b>Jan. 16, 1899</b> <span style="float: right;"><b>72</b></span></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Retired Tool &amp; Die Maker</b></p>			<p>11. BIRTHPLACE (State or foreign country)</p> <p><b>Germany</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>U.S.A.</b></p>
<p>13. FATHER'S NAME</p> <p><b>Paul Patzold</b></p>			<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Marie Dorn</b></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)</p> <p><b>No</b></p>		<p>16. SOCIAL SECURITY NO.</p> <p><b>212-07-5414</b></p>		<p>17. INFORMANT <span style="float: right;">ADDRESS</span></p> <p><b>Mrs Louise Patzold</b> <span style="float: right;"><b>Same</b></span></p>	
<p>18. <b>410.9</b> I <span style="float: right;">CAUSE OF DEATH</span></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION</p> <p><b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p> <p><b>0</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (the hospital) attended the deceased from <b>Jan 5 1972</b> to <b>January 13 1972</b>, that (I) (we) last saw the deceased alive on <b>Jan 5 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <span style="float: right;">DEGREE</span></p> <p><b>Charles E Carr M.D.</b> <span style="float: right;"><b>DEGREE</b></span></p>				<p>23B. DATE SIGNED</p> <p><b>1/14/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>				<p>23D. ADDRESS</p>	
<p><b>Charles E Carr M.D.</b></p>				<p><b>3900 North Charles St Baltimore, Md</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>		<p>24B. DATE</p> <p><b>1/17/72</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY</p> <p><b>Gardens Of Faith</b></p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p><b>Baltimore Maryland</b></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">25B. NAME OF REGISTRAR</span></p> <p><b>JAN 17 1972</b> <span style="float: right;"><b>Leopold J Ruck Inc. Baltimore, Md</b></span></p>			

January 19, 1952

Box 1000, 1st Fl.

Belmont

1000 North Charles St Baltimore, Md

2101 Woodburn Ave

Jan 10, 1952

Make White

Germany

White Rock & Blue Marker

White Room

Room 1, 2nd Fl.

1000 North Charles St Baltimore, Md

to

1000 North Charles St Baltimore, Md

Charles E. Carr M.D.

Baltimore Maryland

Department of Path

1952

Box 1000

1000 North Charles St Baltimore, Md

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		May		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LOTTIE <del>MAE</del> FREEMAN</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 13, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>434 111chester Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1972 5:37 A.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b>					
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>July 26, 1901</b>		10. AGE (In years last birthday) <b>70</b>		E. STREET AND NUMBER <b>434 111chester Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF <b>USA</b>		13. FATHER'S NAME <b>Augustus Rivers</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>-</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>215-50-2143</b>		18. INFORMANT <b>Charles W. Freeman</b> ADDRESS <b>117 Byway Rd. Owings Mills</b>	
19. <b>41241</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 13, 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-260		72 00442		BALTIMORE CITY HEALTH DEPARTMENT		72 00442	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Addie K. Fischer</b>				2. DATE AND HOUR OF DEATH <b>1/11/72 8:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>				A. STATE <b>Maryland</b>		C. COUNTY <b>1512</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2801 Shirey Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/11/07</b>	9. AGE (in years last birthday) <b>64</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Arthur F. Caltrider</b>				14. MOTHER'S MAIDEN NAME <b>Emma King</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-01-3320</b>		17. INFORMANT <b>William Fischer, 2801 Shirey Ave.</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic cancer of the breast.</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
<b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>12/31/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/31/71</b> to <b>1/11/72</b> that (I) (we) last saw the deceased alive on <b>1/11/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Michael A. Silverman MD</b>				23B. DATE SIGNED <b>1/11/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Michael A. Silverman MD</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Barbara J. Z...</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Rick, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-516		72 00443		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00443	
BIRTH NO.		LILY		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DANFORTH, Lillie L.				2. DATE AND HOUR OF DEATH 1-13-72 3:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1902			
FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW NURSING HOME		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1213 Light St Baltimore, Md		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) millinery		10B. KIND OF BUSINESS OR INDUSTRY Dept Store		9. AGE (In years last birthday) 83		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Steven Heck				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-1250		17. INFORMANT Sammie Gordon Mallore		ADDRESS 2238 E Baltimore Ave Baltimore, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Terminal Bilateral Pneumonia				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: A. S. C. U. disease		7 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/31 1971 to 1/13 1972 that (I) (we) last saw the deceased alive on 1/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Blum				23B. DATE SIGNED 1/14/72		23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/15/72		24C. NAME of CEMETERY or CREMATORY Western Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert E. Zuber, M.D.		25C. FUNERAL DIRECTOR John J. Chalk & Son Inc.		ADDRESS 901 Hollins St. 81223	

12 11/10

23500 58

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-610		72 00444		BALTIMORE CITY HEALTH DEPARTMENT		72 00444	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Kirby, Edward Paul				2. DATE AND HOUR OF DEATH Jan. 12, 1972 12:45 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital 43		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 2505	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-1899 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY LAW		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph				14. MOTHER'S MAIDEN NAME Katherine Minster			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 219-26-5218-A		17. INFORMANT Wife		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 576.0 I Hepatic Coma CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Laennec cirrhosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from Dec. 4, 1971 to Jan. 12, 1972 that (X) (we) last saw the deceased alive on Jan. 12, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chiu Sung Chan				23B. DATE SIGNED Jan. 12, 1972			
23C. PHYSICIAN'S NAME (Type) Chiu Sung Chan		23D. ADDRESS South Baltimore General Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-14-72		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy Glen Burnie MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR R. E. Z. 2 0 0		25C. FUNERAL DIRECTOR H. H. F. H. H. 4200 PENNINGTON AVE.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-450		72 00445		BALTIMORE CITY HEALTH DEPARTMENT		72 00445	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Stella C. Toolan</i>				2. DATE AND HOUR OF DEATH <i>Jan. 12, 1972</i>   <i>6:30 P.</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Harford Gardens Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2201</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>223 E. Churchill Street</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 21, 1902</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sewing Machine operator</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Jesse Caldwell</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-07-3290</i>		17. INFORMANT ADDRESS <i>John F. Toolan 5319 Patrick Henry Drive</i>			
18. <i>174X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Breast</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE</i> DUE TO, OR AS A CONSEQUENCE OF: <i>3 years</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>12/13/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 13</i> 19 <i>71</i> to <i>Jan</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Jan 11</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Koy M. Zimmerman M.D.</i>				23B. DATE SIGNED <i>1/14/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Koy M. Zimmerman M.D.</i>	
23D. ADDRESS <i>3202 Harford Rd., Baltimore, Md.</i>							
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>JAN 17 1972</i>		25B. NAME OF REGISTRAR <i>John J. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>One Cubby Funeral Homes 130 E. Fort Ave.</i>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-452		72 00446		72 00446	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Myrtle McClure Williams			January 11, 1972 8:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Long Green Nursing Home			Maryland Baltimore 2768		
			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			509 E. Lake Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 4, 1887	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Homemaker			Missouri		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Own Home			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Gilbert E. McClure			?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No None					
17. INFORMANT			ADDRESS		
Family records					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the injury or complication which caused death.)			A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			B. cerebral thrombosis acute		
DISEASES OR CONDITIONS, if a rise to the above cause (A) UNDERLYING CONDITION lost.			C. cerebral arteriosclerosis normal		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
40/29/71			Heart & coronary		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
No					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12/1/1971 to 1/11/1972 that (I) (we) last saw the deceased alive on 12/13/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
William F. Renner, M.D.			1/13/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
William F. Renner, M.D.			3222 St. Paul St., Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Jan. 13, 1972		Prospect Hill Cemetery	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Towson, Maryland		JAN 17 1972		John E. Fisher, M.D.	
25A. FUNERAL DIRECTOR		25B. ADDRESS		25C. NAME OF REGISTRAR	
John Burns & Sons, Towson, Md.				John Burns & Sons, Towson, Md.	

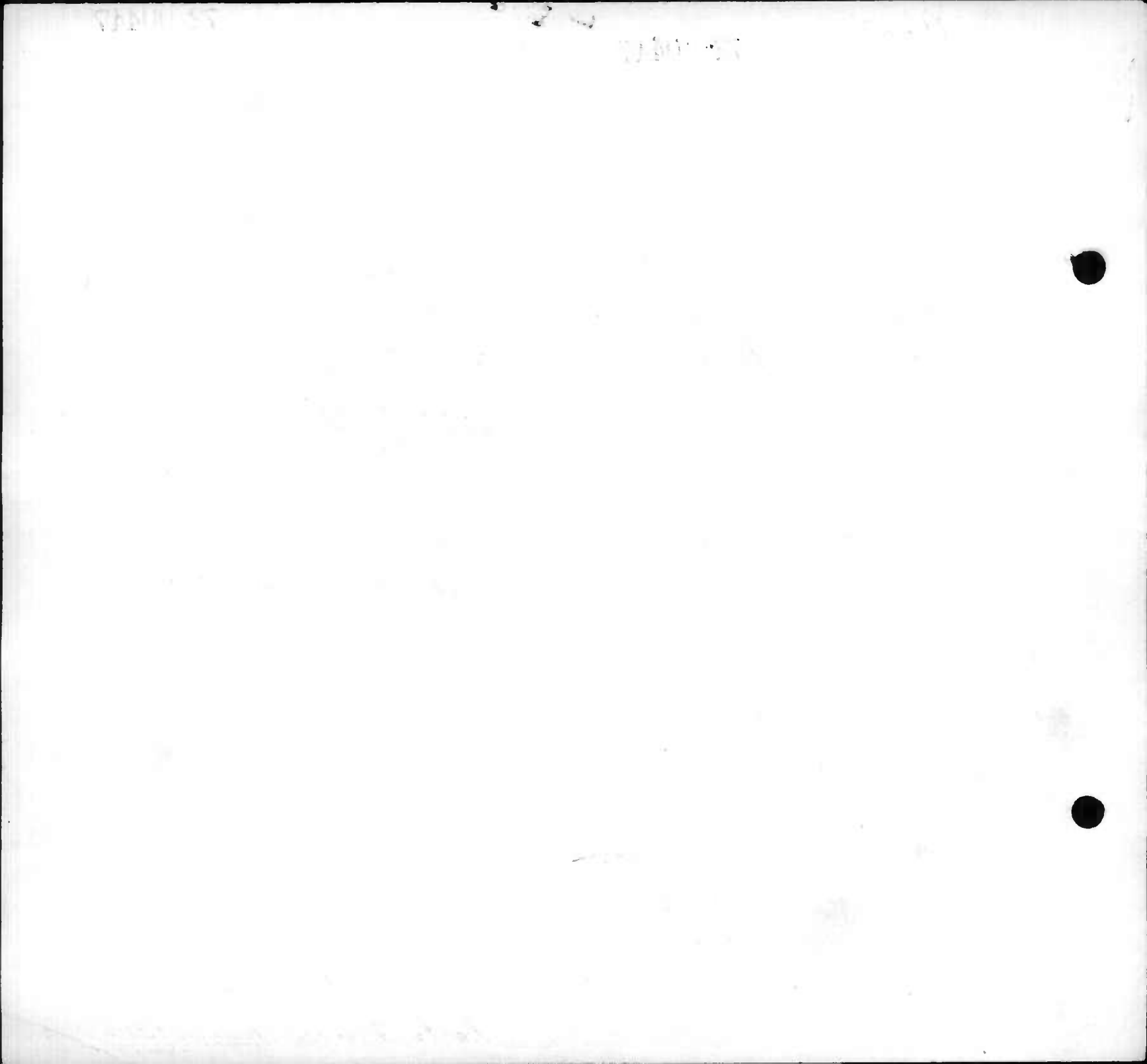




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00447	
72 00447 CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. C-600		1. NAME OF DECEASED (Type or Print) LEROY CHERRY		2. DATE AND HOUR OF DEATH 1-13-72 7:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MD BALT 1102		
5. SEX M			6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY J.H. Univ.		8. DATE OF BIRTH 2-3-24	
13. FATHER'S NAME George Cherry		14. MOTHER'S MAIDEN NAME IRENE SIMMONS		9. AGE (In years last birthday) 47	
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 229-14-231		11. BIRTHPLACE (State or foreign country) MARYLAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 570X I NECROSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF: HEPATOTOXIN, type UNKNOWN ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT Lillian Cherry 95. Arlington Ave		12. CITIZEN OF WHAT COUNTRY? ADDRESS	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-11-72 19 to 1-13 1972 that (I) (we) last saw the deceased alive on 1-13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Grasso M.D.				23B. DATE SIGNED 1-13-72	
23C. PHYSICIAN'S NAME (Type) MICHAEL GRASSO M.D.				23D. ADDRESS Maryland General	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/72		24C. NAME OF CEMETERY or CREMATORY Arbutus mem. P.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert J. ...		25C. FUNERAL DIRECTOR Lock's Funeral Home	
				25D. LOCATION (City, town, or county) (State) Arbutus, Md.	
25E. ADDRESS 1304 ... Ave.					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-654		72 00448		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00448	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PURNELL, ELEANOR				2. DATE AND HOUR OF DEATH JAN 14, 1972 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 806			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1505 E. LANVALE ST			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-24	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WALLER, LEWIS				14. MOTHER'S MAIDEN NAME ? DOROTHY WALLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Dorothy Cannon 1720 N. BROADWAY			
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE (2) CVA DUE TO, OR AS A CONSEQUENCE OF: (B) Essential Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 4+ years							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Jan 9, 1972 to Jan 14, 1972 that (1) (we) last saw the deceased alive on Jan 14, 1972 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas R. Hodous, M.D.				23B. DATE SIGNED Jan 14, 1972		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) DR. THOMAS HODOUS				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/72		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem		24D. LOCATION (City, town, or county) (State) 5501 Frederick Rd	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR R. J. Locks		25C. FUNERAL DIRECTOR Joseph B. Locks		ADDRESS 1304 N. Central Ave	

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2410 55 2410 55

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620 72 00449		BALTIMORE CITY HEALTH DEPARTMENT		72 00449	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>MORRIS WILLIAM V.</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 8 1972</u>   <u>4:45</u> <u>AM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u> <u>4-8</u>			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HARFORD</u> C. CITY OR TOWN <u>ABERDEEN</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>P.O. BOX 233 PRITCHARD AVE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-12-88</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Conductor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>War I</u>		16. SOCIAL SECURITY NO. <u>217-18-3691</u>		17. INFORMANT <u>Wife - 8-6-2 - Pritchard Ave.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma Lung.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>with metastasis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1-6-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-22-1971</u> to <u>1-8-1972</u> that (I) (we) last saw the deceased alive on <u>1-8-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael Russo M.D.</u>			23B. DATE SIGNED <u>1-8-72</u>		23C. PHYSICIAN'S NAME (Type) <u>MICHAEL G. RUSSO M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/12/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oakpepper National</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>			25B. NAME OF REGISTRAR <u>Robert A. Fisher</u>		25C. FUNERAL DIRECTOR <u>Robert W. Wadsworth Jr. - Tarring, Tenn.</u>

Handwritten notes, possibly a list or account, located in the upper left quadrant of the page.

Handwritten notes, possibly a list or account, located in the upper right quadrant of the page.

Handwritten notes at the bottom of the page, possibly a summary or conclusion.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>15-630</b> <b>72 00450</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>72 00450</b>	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>William Barrett</b>			I-10-72		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF DECEASED 719 *Portland Street HOSPITAL OR INSTITUTION			A. STATE <b>Md</b> B. COUNTY <b>BALTI.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b> D. STREET ADDRESS (If rural, give location) <b>719 PORTLAND ST</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>12-18-087</b>	9. AGE (In years last birthday) <b>84</b>	(If Under 1 Yr. Months: Days: (If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Re Grain Elevator</b>		<b>Va</b>		<b>USA</b>	
13. FATHER'S NAME <b>William Barrett</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		<b>705-10-5995</b>		<b>Rosie C. Barrett-719 Portland St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>185X I</b>			CAUSE OF DEATH <b>Carcinoma of Prostate 2 1/2 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-8-1972</b> to <b>1-14-1972</b> , that (I) (we) last saw the deceased alive on <b>1-4-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William H. Wofford</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/12/72</b>
23C. PHYSICIAN'S NAME (Type) <b>William H. Wofford</b>			23D. ADDRESS <b>515 N. AVENUE AVE 1321 BALTIMORE MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>1-14-72</b>		<b>Mount Auburn St</b>	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ZIP CODE	
<b>Balti City</b>		<b>Md</b>		<b>11200</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>JAN 17 1972</b>		<b>Beck</b>		<b>123 W. Montgomery St</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>AARON DONALDSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5002 St. George's Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>January 12, 1972 7:50 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2710</b>	
9. DATE OF BIRTH <b>10-12-1913</b>		10. AGE (In years last birthday) <b>58</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Raleigh, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Donaldson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Animal Care Taker Lab</b>	
15. MOTHER'S MAIDEN NAME <b>Sofenia Rogers</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>217-16-6242</b>		18. INFORMANT <b>Mrs Ruby Donaldson</b>	
19. CAUSE OF DEATH <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural hematoma</b>	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/12/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-15-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Ralph J. Collick</b>	
25C. FUNERAL DIRECTOR <b>Ralph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>	

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• *Journal of Management Education* 25(10):1133-1144

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES TOWNES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>January 12, 1972</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12, 1972 1:41 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>John Hopkins Hospital (DOA)</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>833</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12-12-1919</b>		10. AGE (In years last birthday) <b>52</b>		E. STREET AND NUMBER <b>1419 N. Milton Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joe Tinsley</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		15. MOTHER'S MAIDEN NAME <b>Selena Townes</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-05-7330</b>		18. INFORMANT <b>Mrs. Estelle Goff 1606 E. Preston St.</b>	
19. <b>780.2</b>		CAUSE OF DEATH <b>Death apparently occurring during seizure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
20A. DATE OF OPERATION <b>1-17-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 13, 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		25D. ADDRESS <b>2431 E. Preston St.</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>7-636</b>      <b>72 00453</b>      BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00453</b></p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>WILLIE MAE FREDERICK</b></p>		<p>2. DATE AND HOUR OF DEATH <b>1-10-72</b>      <b>11:15 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b>      B. COUNTY <b>808</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b>      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1815 E. CHASE ST.</b></p>	
<p>5. SEX <b>FEMALE</b></p>	<p>6. RACE <b>NEGRO</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-15-10</b></p>
<p>9. AGE (In years last birthday) <b>61</b></p>		<p>If Under 1 Yr. Months    Days    If Under 24 Hrs. Hours    Min.</p>	<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Hand</b></p>
<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Lewisburg N.C.</b></p>	<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>
<p>13. FATHER'S NAME <b>LOW GILL</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Lillie Fitts</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. <b>216-16-1950</b></p>	<p>17. INFORMANT <b>Miss Tessie Fredrick</b></p>
<p>18. <b>438701</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cerebrovascular Disease</b></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b></p>	
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>0</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> 19 <b>72</b> to <b>1/10</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/10</b> 19 <b>72</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>W. Rohde MD</b></p>		<p>23B. DATE SIGNED <b>1/10/72</b></p>	<p>23C. PHYSICIAN'S NAME (Type) <b>W. Rohde</b></p>
<p>23D. ADDRESS <b>601 N. Broadway Balto Md.</b></p>		<p>23E. DEGREE <b>MD</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>1-14-72</b></p>	<p>24C. NAME OF CEMETERY or CREMATORY <b>Md. National Memorial PK.</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Laurel, Md.</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b></p>	<p>25B. NAME OF REGISTRAR <b>Robert E. Talley</b></p>	<p>25C. FUNERAL DIRECTOR ADDRESS <b>Randolph J. Collick 2431 E. Oliver St.</b></p>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00454

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Moses J. Stewart, Sr.</b> <b>John Moss Stewart</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 6 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 6 72 9:34 p.</b> M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>Separated</del> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>1-23-1904</b>		10. AGE (In years last birthday) <b>67</b>	
11. BIRTHPLACE (State or foreign country) <b>Woodward, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.B.</b>	
13. FATHER'S NAME <b>Norah Stewart</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>	
15. MOTHER'S MAIDEN NAME <b>Sylvia Caldwell</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>218-18-6323</b>		18. INFORMANT <b>Samuel R. Stewart 2812 Oswego Ave.</b>	
19. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> <b>PART Autopsy</b> <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, MD</b> M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-11-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-530		72 00455		BALTIMORE CITY HEALTH DEPARTMENT		72 00455	
BIRTH NO.		72 00455		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>HUNT, EMANUEL LEE</b>				2. DATE AND HOUR OF DEATH <b>January 9, 1972</b> <b>9:40 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2305 E. Biddle St.</b>							
5. SEX <b>Male</b>	6. RACE <b>Negroid</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-14</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Hunt</b>				14. MOTHER'S MAIDEN NAME <b>Lelia Jones</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9-14-43 to 12-3-45</b>		16. SOCIAL SECURITY NO. <b>216-10-5201</b>		17. INFORMANT <b>Records V. A. Hospital</b> ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Maryland</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>150X I</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 Years</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Years</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>January 3, 19 72</b> to <b>January 9, 19 72</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>January 9, 19 72</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Arthur C. Burdett M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-9-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARTHUR C. BURDETT, M.D.</b>				23D. ADDRESS <b>V. A. Hospital</b> <b>3900 Loch Raven Blvd., Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-13-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Probuens Memorial Park Probusus, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>Probusus, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Md.</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>	



S-423

72 00456 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00456

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Luther <del>Shelkett</del> Shelkett		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 1	Day 11	Year 72	Hour 11:10A. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2103 Maryland Avenue		3. DATE PRONOUNCED DEAD Month 1 Day 11 Year 72		Hour 11:10A. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1206							
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5/24/08	10. AGE (In years lost birthday) 63	11. BIRTHPLACE (State or foreign country) Danville Va		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John R. Shelkett		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur					
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes War II					
17. SOCIAL SECURITY NO. 215-03-9274		18. INFORMANT ADDRESS Rd James Shelkett 406 Oakwood Station					
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-11-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/13/72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Taylor Ave Balto, Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Frederick J. Cook 7200 Harford Rd			

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SS 10020



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00457</b></p>	
<p><b>7-236 72 00457</b></p> <p><b>BIRTH NO.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p><b>JAN. 14, 1972 4:10 p.m.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>RICHARD T. FOSTER</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1509</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3919 Carlisle Ave. Baltimore, Md.</b></p>		<p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>3919 Carlisle Ave.</b></p>	
<p><b>5. SEX</b> <b>M</b></p>	<p><b>6. RACE</b> <b>B</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>9/22/98</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Western Electric Co.</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>Austin Foster</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>212-05-7228</b></p>	
<p><b>17. INFORMANT</b> <b>Juliette Corbin</b></p>		<p><b>ADDRESS</b> <b>same</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Myocardial Infarction</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hour</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Dis. unknown</b></p>		<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Cerebral Thrombosis</b></p>	
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>Jan 1971</b></p>		<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>	
<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY? (Yes or No)</b> <b>no</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 71</b> <b>to</b> <b>1/14 19 72</b> <b>that (I) (we) last saw the deceased alive on</b> <b>1/14 19 72</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>D. W. STEWART, M.D.</b></p>		<p><b>23B. DATE SIGNED</b> <b>1/14/72</b></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <b>D. W. STEWART, M.D.</b></p>		<p><b>23D. ADDRESS</b> <b>2300 Garrison Blvd</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>EXH 172 Burial 1/18/72</b></p>		<p><b>24B. DATE</b> <b>1/18/72</b></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 17 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Kenneth Lee</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>6611 Park Heights Ave.</b></p>		<p><b>ADDRESS</b></p>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-143 72 00458		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00458	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>BARBARA BAUBLITZ</b>			2. DATE AND HOUR OF DEATH <b>1-14-72 01:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSP.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2716</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3127 WOODLAND AVE #15</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>07-22-1938</b>	9. AGE (In years last birthday) <b>33</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>File Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Richard H. Baublitz 3127 Woodland Ave</b>	
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>ETIOLOGY UNKNOWN</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>01-12</b> 19 <b>72</b> to <b>01-14</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>01-14</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Peter Oroszlan</b>			23B. DATE SIGNED <b>01-14-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>PETER OROSZLAN MD</b>			23D. ADDRESS <b>3 HAMIL RD APT 5</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Nader, M.D.</b>		25C. FUNERAL DIRECTOR <b>James M. O'Leary</b>	
				ADDRESS <b>322 S. North St</b>	



25-10-55

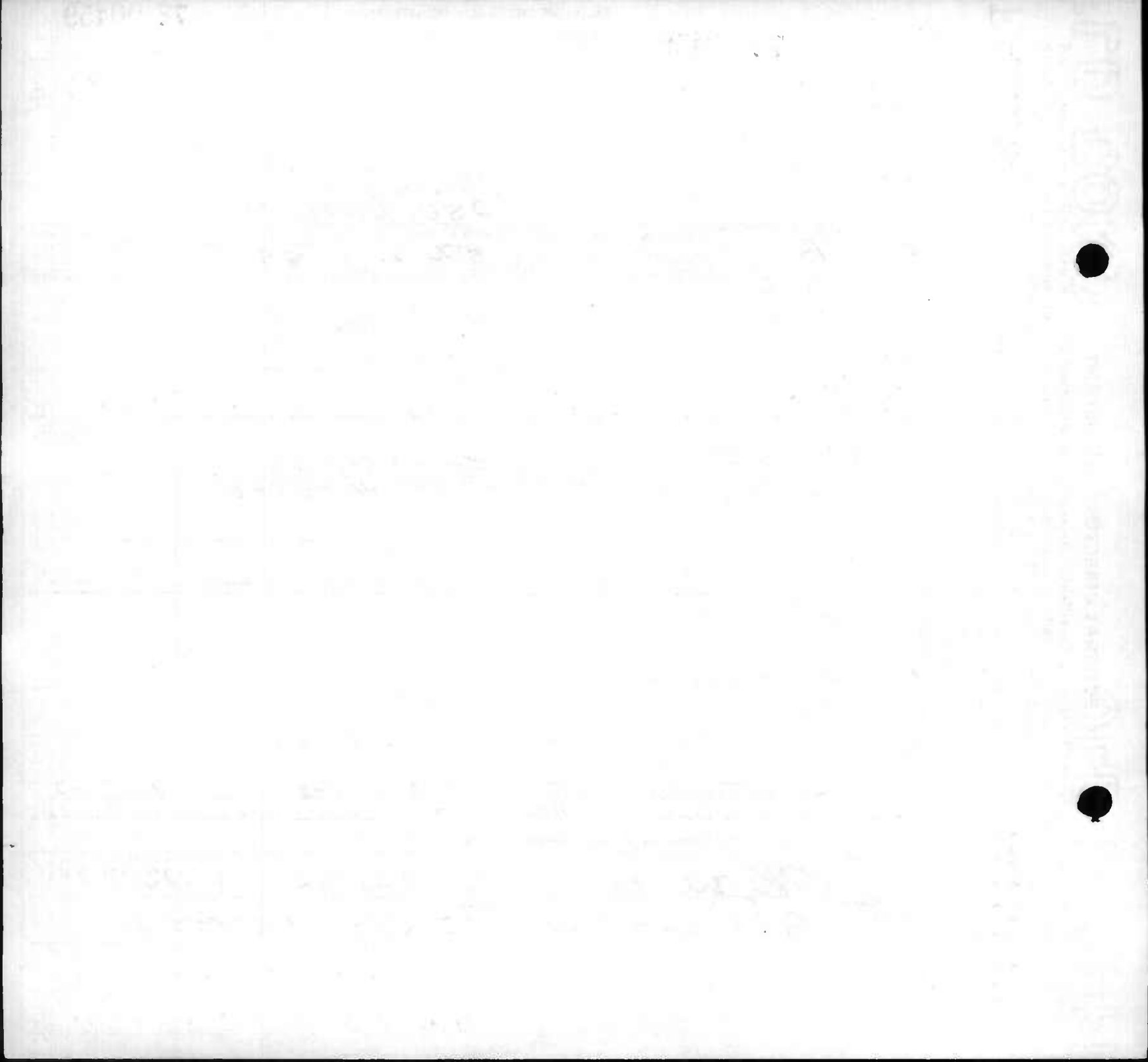
25-10-55



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00459		REG. NO. _____	
K-520				72 00459			
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LILLIAN KNOX</b>				2. DATE AND HOUR OF DEATH <b>11/16/72 9:00p M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1513</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
42				E. STREET AND NUMBER <b>2509 OSWEGO AVE 21215</b>			
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/12</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Char-Woman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Mag + Electric</b>		11. BIRTHPLACE (State or foreign country) <b>CAMDEN S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>ASbury Walker</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Hart</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-24-1690</b>		17. INFORMANT <b>Arthur KNOX Jr.</b>		ADDRESS <b>2509 OSWEGO AVE.</b>	
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>INTRA CEREBRAL</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HAEMORRHAGE</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HAEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>11/13/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTRA CEREBRAL HAEMORRHAGE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>12/25 1972</b> to <b>11/14 1972</b> that (H) (we) last saw the deceased alive on <b>11/14 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. KERZNER M.D.</b>				23B. DATE SIGNED <b>11/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>B. KERZNER M.D.</b>	
23D. ADDRESS <b>SINAI HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/19/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION <b>ANNE ARUNDEL Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>W. F. Spicer</b>		25C. FUNERAL DIRECTOR <b>W. F. Spicer</b>			
				ADDRESS <b>1639 N. Broadway</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>H-630</b>      <b>72 00460</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>72 00460</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Coca Howard</i></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>1-12-72 9:35 A.M.</i></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <i>Bolton Hill Nursing</i></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2003</i></p>	
<p><b>5. SEX</b> <i>F</i>      <b>6. RACE</b> <i>Black</i></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Homemaker</i></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>Hampton VA</i></p>	
<p><b>13. FATHER'S NAME</b> <i>John H. Brown</i></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <i>Susan A. Karrow</i></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p><b>16. SOCIAL SECURITY NO.</b> <i>226-104-998</i></p>	
<p><b>17. INFORMANT</b> <i>Medical Record</i></p>		<p><b>ADDRESS</b></p>	
<p><b>18. CAUSE OF DEATH</b> <i>412.4 I</i></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>3 days</i></p>	
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Terminal Bilateral Pneumonia</i></p>		<p><b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <i>A.S.C.V. Disease</i></p>	
<p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> <i>Sensitivity - C.B.S.</i></p>		<p><b>(D) DUE TO, OR AS A CONSEQUENCE OF:</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY</b> (Yes or No) <i>No</i></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <i>12/28</i> 19 <i>70</i> to <i>1/11</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1/11</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>Joseph S. Blum MD</i></p>		<p><b>23B. DATE SIGNED</b> <i>1/18/72</i></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <i>JOSEPH S. BLUM MD</i></p>		<p><b>23D. ADDRESS</b> <i>115 W. CALVERT ST.</i></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Interred</i></p>		<p><b>24B. DATE</b> <i>1/14/72</i></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Lanham Plot</i></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>Hampton VA</i></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JAN 17 1972</i></p>		<p><b>25B. NAME OF REGISTRAR</b> <i>Robert E. Harker, M.D.</i></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <i>John S. D...</i></p>		<p><b>ADDRESS</b></p>	

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FUNERAL DIRECTOR: IMPORTANT

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72 00461		BALTIMORE CITY HEALTH DEPARTMENT		72 00461	
G-455		CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DAN GALLMAN		JAN 15, 1972 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC		A. STATE MARYLAND		B. COUNTY BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3488 DOLFIELD AVENUE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-08	9. AGE (In years last birthday) 64	10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10B. KIND OF BUSINESS OR INDUSTRY ARUNDEL SALES		11. BIRTHPLACE (State or foreign country) NEWBERRY, S.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHNNIE GALLMAN		14. MOTHER'S MAIDEN NAME ELIZA SHIELDS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 248 05 3814		17. INFORMANT Adelaide Gallman 3488 Dolfield Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 151.9 I GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) CA OF STOMACH (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS. YEARS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Jan 15 1972 to Jan 15 1972 that (I) (we) last saw the deceased alive on Jan 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE F. Weinstein MD		23B. DATE SIGNED 1-15-72			
23C. PHYSICIAN'S NAME (Type) FRANKLIN WEINSTEIN MD		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE INC.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/19/72		24C. NAME of CEMETERY or CREMATORY MT. AUBURN CEMETERY	
24D. LOCATION BALTIMORE		24E. (City, town, or county)		24F. (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Lewis T. Gwynn		25C. FUNERAL DIRECTOR 4517 PARK HEIGHTS AVE.	

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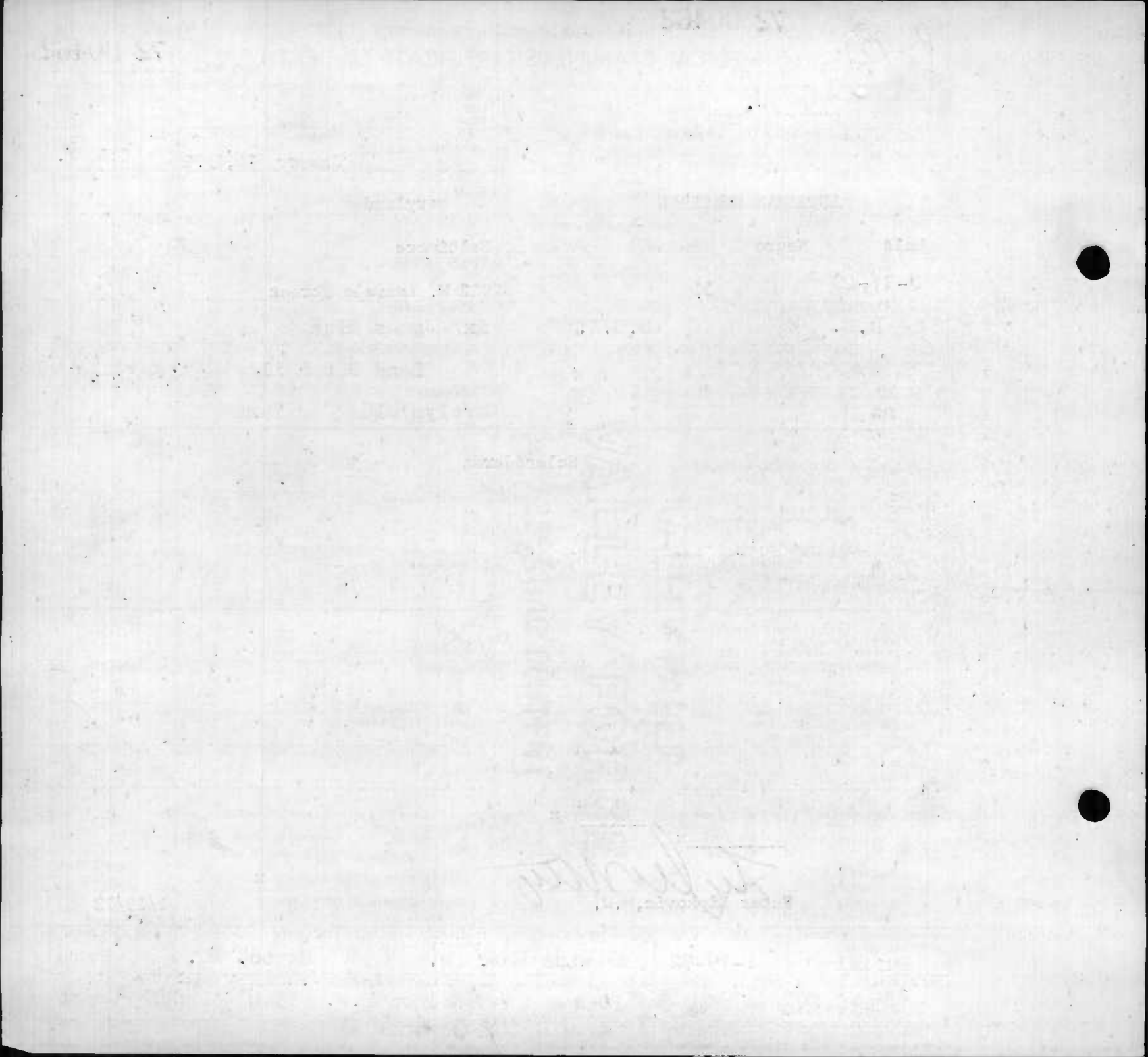
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE BLUE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>January 14, 1972 1:10 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8-31-40</b>		10. AGE (In years last birthday) <b>31</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF U.S.A. <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Lena Hatchell</b>		18. INFORMANT <b>Carolyn Blue</b>	
19. <b>734.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Scleroderma</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED <b>1/15/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balbo. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>		25D. ADDRESS <b>1348 Calhoun Street</b>	

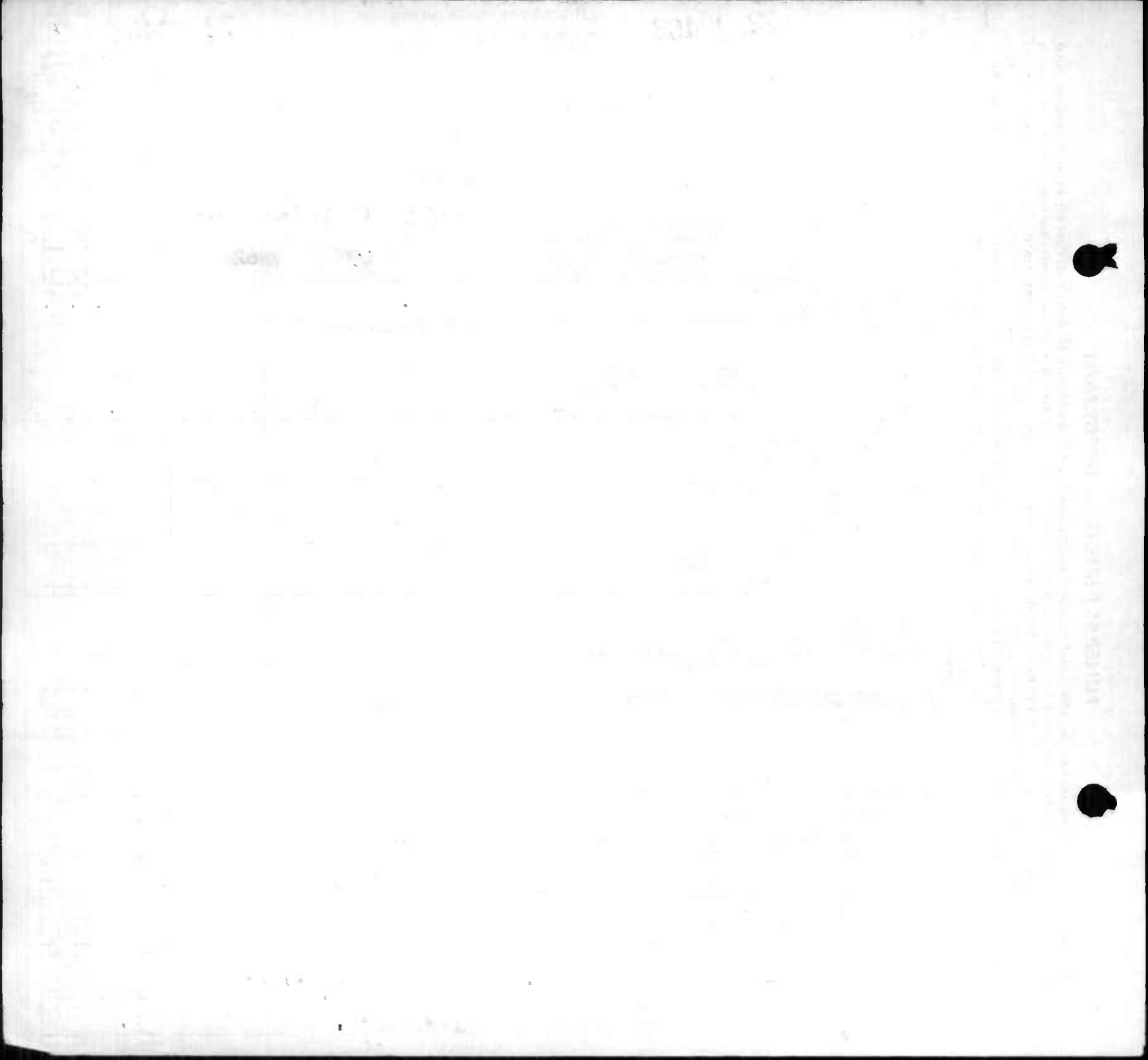




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00463</b>	
S-530 72 00463		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Smith, John Horace</b>		2. DATE AND HOUR OF DEATH <b>Jan 14 1972 10:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hosp</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>1538</b>			
5. SEX <b>M</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12-25-09</b>		9. AGE (In years last birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISABLE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>217-03-1735</b>		17. INFORMANT ADDRESS <b>Edward Smith 102 Allendale Rd. 21229</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b> <b>Pulmonary emphysema</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>edema</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>Jan 11 1972</b> to <b>Jan 14 1972</b> that (I) (we) lost saw the deceased alive on <b>Jan 14 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>V. Chitraplee</b>		23B. DATE SIGNED <b>Jan - 14, 72</b>		23C. PHYSICIAN'S NAME (Type) <b>V. Chitraplee</b>	
23D. ADDRESS <b>Provident Hosp.</b>		23E. FUNERAL DIRECTOR <b>V. Bailey</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>			
25B. NAME OF REGISTRAR <b>R. E. F. 1348</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1348 Calhoun St.</b>			



P.630 72 00464

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00464

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES PRATT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>REAR OF 1424 Druid Hill Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 11, 1972 4:24 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3-23-20</b>		10. AGE (In years last birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>212-14-2302</b>	
18. INFORMANT <b>Estelle Smith</b>		ADDRESS <b>1315 Woodward St</b>	
19. <b>E 965X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Gunshot wound of head</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Rear Yard</b>	
22C. WHERE DID INJURY OCCUR? <b>1424 Druid Hill Avenue</b>		22D. TIME (Month) (Day) (Year) (Hour) <b>1-11-72 4:20 P.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/12/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Wm. A. Bailey</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kelson F. W.</b>		ADDRESS <b>1348 Calhoun St.</b>	

NOV 11 1911

NOV 11 1911

Wash. D.C. 11/11/11

My dear Mr. [illegible]

I have just received your letter of the 10th inst.

and am glad to hear from you.

Very truly yours,

[illegible signature]

CC

15 [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible signature]

72 00465

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00465

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Mabel McDonald				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 14 72 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1217 W. Mosher St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 1 14 72 6:30 a. M.			
6. SEX female				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-18-05				10. AGE (In years last birthday) 66		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Samuel Gaines		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
15. MOTHER'S MAIDEN NAME Sarah Forester				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220146404	
18. INFORMANT Harry McDonald				19. ADDRESS 3108 Jeffery Rd. 21207			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lpkovic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 1/14/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-17-72			
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.				24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972				25B. NAME OF REGISTRAR Kelson F.H.			
25C. FUNERAL DIRECTOR V. Bailey				ADDRESS 1348 Calhoun Street			

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72 00466

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00466

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Jonnie E. Stubbs</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 15 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1 00 1437 E. Eager Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 15 72 10:00 a M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7-17-26		10. AGE (In years last birthday) 45	
11. BIRTHPLACE (State or foreign country) IRVING N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		17. SOCIAL SECURITY NO. 239-38-8743	
18. INFORMANT MARY THOMAS		ADDRESS 2720 Beryl Ave.	
19. CAUSE OF DEATH E 887 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subdural hematoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) SIDE WALK	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1437 E. Eager St. (side walk) 1002		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) unk unk	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject allegedly fell on side walk, and supposedly fell out of chair.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/16/72			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 1-18-72	
24C. NAME OF CEMETERY or CREMATORY DAVIS Chapel Cemetery		24D. LOCATION (City, town, or county) (State) DUNN N.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR P. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR R. B. Saruggs		ADDRESS 1412 E. Preston St.	



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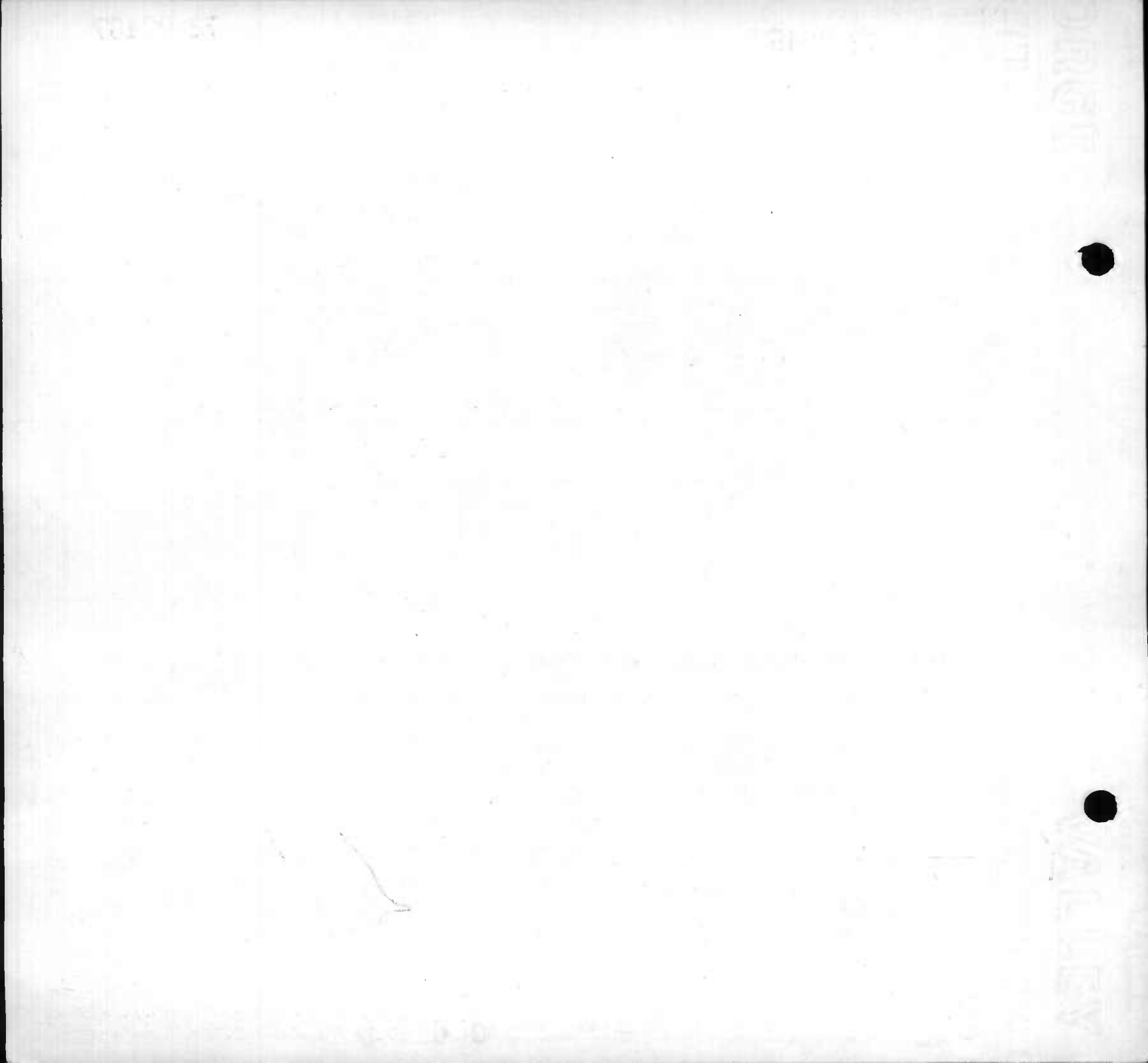
James J. Jones



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00467	
BIRTH NO. 72 00467				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Henry Joseph Goetz</i>			2. DATE AND HOUR OF DEATH <i>January 9, 1972 3:30 A. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			10. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2401</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 1440 Hall ST. Baltimore Md. 21230</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1440 Hall ST.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 26, 1892</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Longshoreman</i>			11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>John Goetz</i>			14. MOTHER'S MAIDEN NAME <i>Anna Marie Goetz</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>215-03-068</i>		
			17. INFORMANT <i>Margaret H. Goetz 1440 Hall ST.</i>		
18. <i>412.41 x 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) <i>arteriosclerotic cardiac vascular disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes mellitus</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>coronary artery disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes mellitus</i> (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>II Upper respiratory infection complicating chronic asthma</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 6</i> 19 <i>67</i> to <i>Jan. 6</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>Jan. 6</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Romulo V. Goco</i> <i>12-11</i>				23B. DATE SIGNED <i>Jan. 9, 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>Romulo V. Goco</i> <i>M.D.</i>				23D. ADDRESS <i>5500 Bowleys Lane Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-12-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Grandview Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Cambria, Youngstown, Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 17 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Baker, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc. 615 East Fort Avenue</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00468		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00468	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Josephine Kozmierski</u>		2. DATE AND HOUR OF DEATH <u>1/11/72</u> <u>17:45 am</u> M.	
3. PLACE (IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21230</u>		C. CITY OR TOWN <u>Baltimore</u> D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT (IN HOSPITAL OR (INSTITUTION, GIVE STREET ADDRESS OR LOCATION)) <u>South Baltimore General Hospital</u>		E. STREET AND NUMBER <u>1323 Cooksietr.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/05</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Miss.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Walter Kozlowski</u>		14. MOTHER'S MAIDEN NAME <u>EVA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>R. Sirithara</u> ADDRESS <u>South Baltimore General Hosp.</u>	
18. <u>427.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>multiple embolism.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>atrial fibrillation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>9/1/72</u> to <u>1/11/72</u> that (I) (we) last saw the deceased alive on <u>1/11/72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>R. Sirithara</u>		M.D. DEGREE		23B. DATE SIGNED <u>1/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. SIRITHARA</u>		M.D. DEGREE		23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/14/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel County Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>		25B. NAME OF REGISTRAR <u>John E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>John E. Talbot, M.D.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00469	
BIRTH NO. 72 00469				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Frank Sokolowski</b>		2. DATE AND HOUR OF DEATH <b>1-6-72</b> <b>5:00 A.M.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2401</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1408 Cooks St Baltimore, Md. 21230</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1408 Cooks St</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-30-98</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>215-09-3330A</b>		17. INFORMANT <b>Mary Sokolowski</b> ADDRESS <b>1408 Cooks St.</b>	
18. <b>162.1 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Carcinoma of the lung</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 7</b> 19 <b>68</b> to <b>1/6/72</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Dec. 12</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1/7/72</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARDO LOZADA M.D.</b>		23D. ADDRESS <b>1228 S. Charles St. Baltimore 21230</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-8-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>			
25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Charles E. Stevens Funeral Home, Inc.</b> ADDRESS <b>1501 East Fort Avenue</b>			



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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00470

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GARLAND P. CAVINESS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTO. GENERAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 14, 1972 7:15 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11-28-17</b>		10. AGE (In years last birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Iron D. Caviness</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2401</b>	
15. MOTHER'S MAIDEN NAME <b>MARTHA MURPHY</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>	
17. SOCIAL SECURITY NO. <b>216-071585</b>		18. INFORMANT ADDRESS <b>Mrs. Peter Caviness 1400 Reynolds St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Chronic obstructive pulmonary disease</b>		20. CAUSE OF DEATH <b>Chronic obstructive pulmonary disease</b>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Acute alcoholic intoxication</b>		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25A. DATE OF OPERATION <b>0</b>		25B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		26B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		26D. HOW DID INJURY OCCUR?	
26E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		26F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
28. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
30. DATE SIGNED <b>1/15/72</b>		31. DATE OF OPERATION <b>0</b>	
32A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		32B. DATE <b>1-19-72</b>	
32C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		32D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
33A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		33B. NAME OF REGISTRAR <b>Robert E. Jaber, M.D.</b>	
33C. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc.</b>		33D. ADDRESS <b>1501 E. Fort Avenue</b>	

1-20-72 - Letter from - Office of the Chief Medical Examiner, Peter Lipkovic; M.D.  
Assistant Medical Examiner

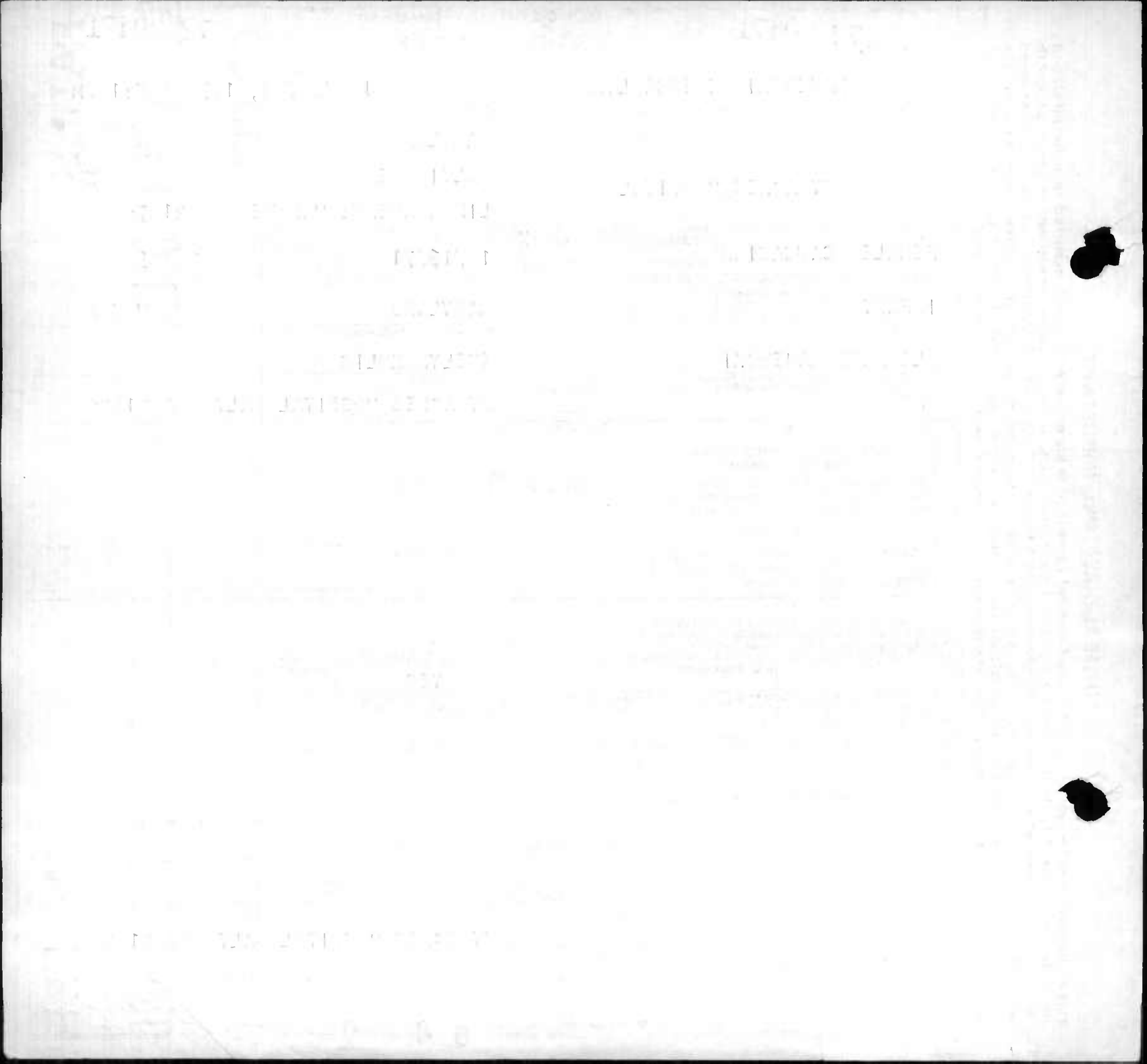
HRS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00471	
BIRTH NO. 72 00471 71-17782				2. DATE AND HOUR OF DEATH JANUARY 8, 1972   5:10PM			
1. NAME OF DECEASED (Type or Print) MAJEWSKI REBECCA LYNN				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY AA 5200			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER LINDA AVENUE HANOVER MD 21076			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/71		9. AGE (In years last birthday) 2 23	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME LEONARD MAJEWSKI				14. MOTHER'S MAIDEN NAME EVELYN KULIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229			
18. CAUSE OF DEATH 759.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE CARDIAC		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks.	
				(B) FAILURE DUE TO TRISOMY DUE TO, OR AS A CONSEQUENCE OF:			
				(C) E SYNDROME			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/29/1971 to 1/8/1972 that (I) (we) lost saw the deceased alive on 1/8/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Azad Cader				23B. DATE SIGNED 1/8/72		23C. PHYSICIAN'S NAME (Type) AZAD CADER MD	
23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-10-72		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles L. Steynus Funeral Home, Inc. 041659 E. FORT AVENUE			





~~ST. MARY ST~~

ST. MARY ST

Coiled Hospital address  
should be 2625 Kroganone

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-524 72 00473		CERTIFICATE OF DEATH		72 00473	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SWINGLE WILLIAM. M.		1-15-1972		6:12 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SO. BALTO GEN. HOSP. 43		A. STATE Md		B. COUNTY BALTO	
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 116 FRANKLIN AVE			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-13	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 156TH LETEN STEEL		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME WILLIAM W		14. MOTHER'S MAIDEN NAME MYRTLE THOMAS.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 170 10 8707		17. INFORMANT William W. Swingle Box 339 A Woodland Road Millersville Md.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH METASTASIZED LUNG CARCINOMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CONGESTIVE HEART FAILURE					
19A. DATE OF OPERATION 1-3-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED R+LUNG MASS		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-3-1972 to 1-15-1972 that (I) (we) last saw the deceased alive on 1-15-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 1-15-72		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS [Signature]		23E. ADDRESS [Signature]		23F. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/72		24C. NAME OF CEMETERY or CREMATORY Kizer Cemetery	
24D. LOCATION Scranton Pa.		24E. LOCATION [Signature]		24F. LOCATION [Signature]	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR McCall Funeral Home 237 Patapsco Ave	

William B.  
Jettison

Myrtle Thomas

Metropolitan Line

Canadian Pacific

3-3-70

1-3-1  
1-2-1

Thompson



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____	
C-455 72 00474				72 00474	
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <u>Elmer W Coleman</u>			2. DATE AND HOUR OF DEATH <u>1-13-72</u> <u>3:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>			A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>3820 milford Ave</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-01</u>	9. AGE (in years last birthday) <u>70</u>	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Coleman</u>			14. MOTHER'S MAIDEN NAME <u>Upperman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-10-7383</u>		
17. INFORMANT <u>Juanita Coleman</u>			ADDRESS <u>3820 Milford Avenue 21207</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ISCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>0</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>69</u> to <u>Jan. 13</u> 19 <u>72</u> . that (I) (we) last saw the deceased alive on <u>Jan</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nathan E. Needle</u>			23B. DATE SIGNED <u>Jan 13/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>NATHAN E. NEEDLE</u>			23D. ADDRESS <u>6506 Park Hts Dr Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-17-72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Armadost Funeral Chapel</u>	
				ADDRESS <u>4600 Liberty Hts</u>	

1954

1954

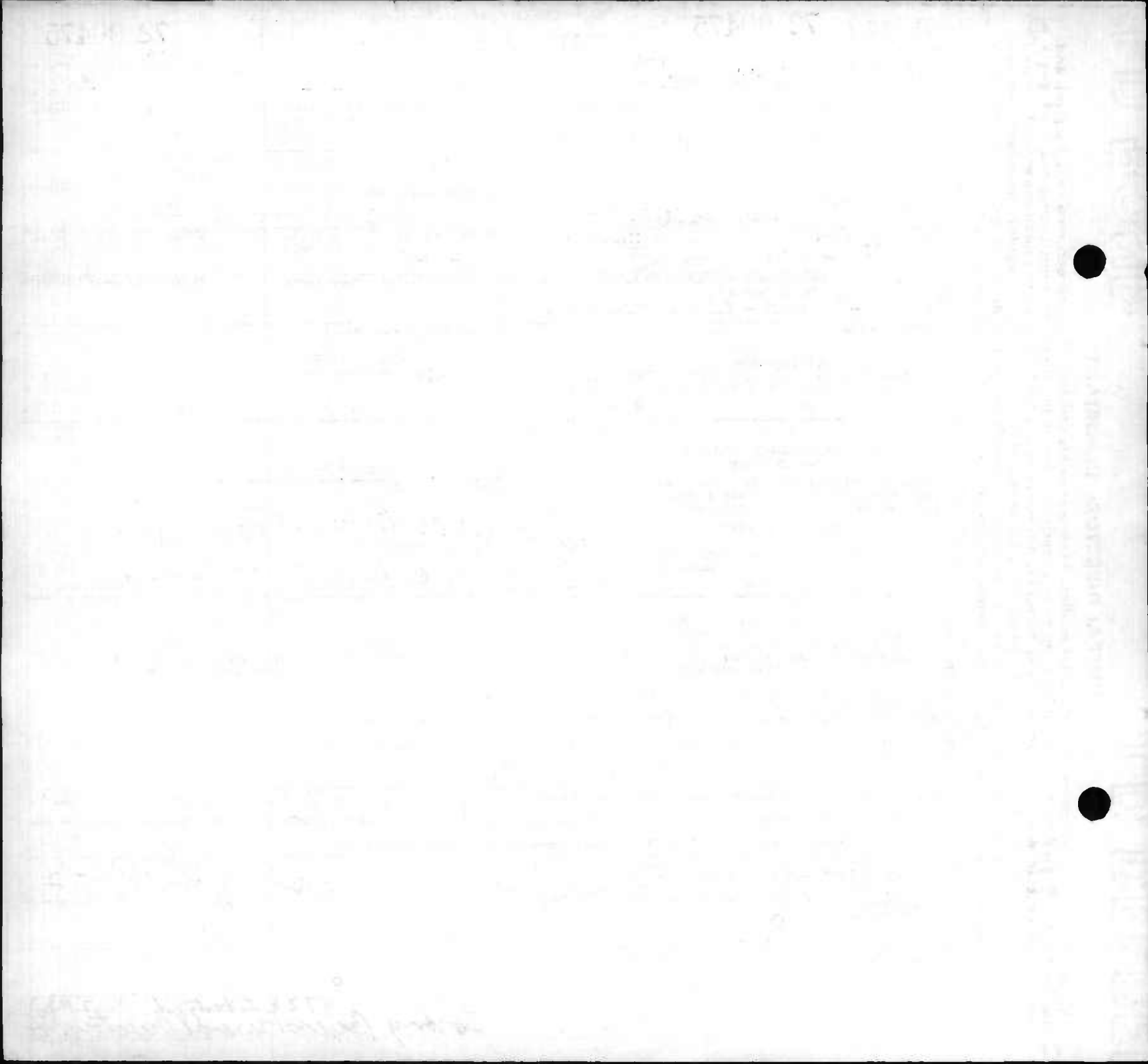
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

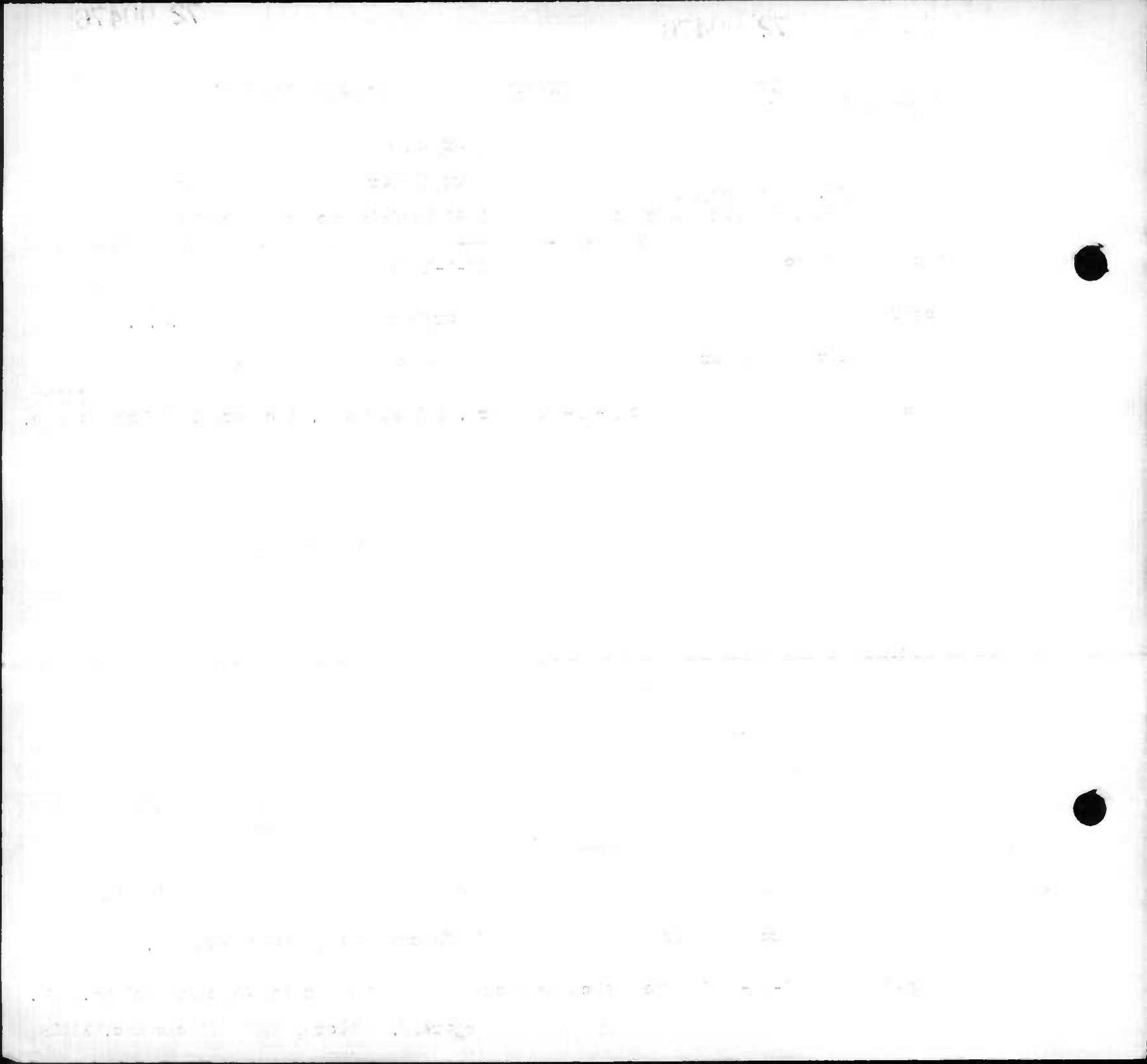
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00475</u>	
M-321 72 00475				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>David F. Metzbower, Sr.</u>				2. DATE AND HOUR OF DEATH <u>1-14-72</u> <u>6:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>37</u> <u>Mercy Hospital, Inc</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2719</u>	
				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5804 Ethelbert Avenue</u> <u>21215</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-02</u>	9. AGE (in years last birthday) <u>69</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Lineman - Balto. Transit Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Metzbower</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Rowlinn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>213-05-9067 A</u>		17. INFORMANT <u>Mrs. Alice E. Metzbower</u> ADDRESS <u>21215</u> <u>5804 Ethelbert Ave.</u>
18. <u>237.61</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bladder tumor, recurrent</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Congestive heart failure</u>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>he</del> (this hospital) attended the deceased from <u>12/18</u> 19 <u>71</u> to <u>1/14</u> 19 <u>72</u> that <del>he</del> (we) last saw the deceased alive on <u>1/14</u> 19 <u>72</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <u>R. Lee</u>				23B. DATE SIGNED <u>Jan 10-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. LEE, MD</u>				23D. ADDRESS <u>MERCY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/17/1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION <u>Woodlawn, Balto., Co. Md.</u>		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>		25B. NAME OF REGISTRAR <u>E. J. ...</u>		25C. FUNERAL DIRECTOR <u>872 2 Liberty Rd. ...</u>	
25D. ADDRESS <u>... Funeral Directors, PA</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-526 72 00476		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00476 REG. NO.	
1. NAME OF DECEASED (Type or Print)		LEO BUENGER		2. DATE AND HOUR OF DEATH January 13, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION  40 St. Agnes Hospital Wilkins & Caton Avenues		A. STATE Maryland		2582	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		C. CITY OR TOWN Morrell Park	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2001 Letitia Avenue 21230			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1901	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Buenger		14. MOTHER'S MAIDEN NAME Anna (Unknown)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 219-05-9456		17. INFORMANT Mrs. Wilhelmina S. Buenger, 2001 Letitia Ave. ADDRESS 21230	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ACUTE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CORONARY INSUFFICIENCY (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-11-1970 to Nov-17, 1970 that (I) (we) last saw the deceased alive on Nov 17, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nureddin Erk		23B. DATE SIGNED 1-14-72		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Nureddin Erk		23D. ADDRESS 7811 Liberty Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-1972		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION Glen Burnie, Anne Arundel Co., Md.		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR E. J. G. G. G.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

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G-612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00477	
72 00477		CERTIFICATE OF DEATH		72 00477	
1. NAME OF DECEASED (Type or Print) <b>NATALA ANNA GERVASI</b>		2. DATE AND HOUR OF DEATH <b>1/14/72 4 35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL 827 LINDEN AVE.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2531</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4901 STAFFORD ST.</b>			
5. SEX <b>Female</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-91</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Anthony Di Prima</b>			
14. MOTHER'S MAIDEN NAME <b>Josephine (Unknown)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>219-12-7373</b>		17. INFORMANT <b>Miss Theresa A. Longo, 4901 Stafford St. 21229</b> <b>Pt. S. CHART</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>571.9 I</b> <b>Acute liver failure</b> <b>CIRRHOSIS OF THE LIVER.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CIRRHOSIS OF THE LIVER.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>11/13/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Cholecystitis</b>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/13/72</b> 19 to <b>1/14/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/14</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1/14/72</b>		23C. PHYSICIAN'S NAME (Type) <b>E. G. DRITSAS M.D.</b>	
23D. ADDRESS <b>1211 F. NORTHERN PKWY 21239</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Entombment</b>			
24B. DATE <b>1-17-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Dulaney Valley Mausoleum</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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<div style="display: flex; justify-content: space-between;"> <span>M-620</span> <span>72 00478</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">72 00478</span>	
BIRTH NO. <span style="font-size: 1.2em;">11-620</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">MORRIS, GLADYS GERTRUDE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">JANUARY 13, 1972</span> <span style="float: right;">5:30 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">ST. AGNES HOSPITAL</span> <span style="font-size: 1.1em;">40 CATON &amp; WILKENS AVENUE</span> <span style="font-size: 1.1em;">BALTIMORE MARYLAND 21229</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.1em;">2551</span> C. CITY OR TOWN <span style="font-size: 1.1em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">901 Calwell Road</span> <span style="float: right;">21229</span>	
5. SEX <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> MALE	6. RACE <span style="font-size: 1.1em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">06 30 04</span> <span style="float: right;">67</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">ACCOUNTANT</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">MARYLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.1em;">ELMER S. WHITE</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">COLWELL EFFIE G. (XXXXXXX) WHITE</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">213 09 8818</span>	
		17. INFORMANT <span style="font-size: 1.1em;">AVE BALTO MD 21229</span> ADDRESS <span style="font-size: 1.1em;">ST. AGNES HOSPITAL CATON &amp; WILKENS</span>	
18. <span style="font-size: 1.2em;">436.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.1em;">Cerebrovascular accident</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">Cerebrovascular accident 3 weeks</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">1 day</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <span style="font-size: 1.1em;">DECEMBER 22</span> 19 <span style="font-size: 1.1em;">71</span> to <span style="font-size: 1.1em;">JANUARY 13</span> 19 <span style="font-size: 1.1em;">72</span> . that <del>(X)</del> (we) last saw the deceased alive on <span style="font-size: 1.1em;">JANUARY 13</span> 19 <span style="font-size: 1.1em;">72</span> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) <del>(not)</del> view the body after death.			
23A. SIGNATURE <span style="font-size: 1.1em;">[Signature]</span>		23B. DATE SIGNED <span style="font-size: 1.1em;">01 XXX 13 72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">JOSE APTER MD.</span>		23D. ADDRESS <span style="font-size: 1.1em;">CATON &amp; WILKENS AVENUE</span>	
24A. BURIAL-CREATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">1-15-1972</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.1em;">Morgan Chapel Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Woodbine, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JAN 17 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Howard M. Hubbard</span>	
		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">21229</span> <span style="font-size: 1.1em;">4107 Wilkens Ave.</span>	

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<b>BIRTH NO.</b> S-632 72 00479		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO.</b> 72 00479	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>Sowards, Mark E. Sr.</b>			<b>2. DATE AND HOUR OF DEATH</b> 1/13/72 12:05 a.m.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>5300</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>232 St. Helena Avenue 21222</b>		
<b>5. SEX</b> Male	<b>6. RACE</b> Caucasian	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 9/1/20	<b>9. AGE</b> (In years last birthday) 51	If Under 1 Tr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Shear Operator Bethlehem Steel			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> _____		
<b>11. BIRTHPLACE</b> (State or foreign country) West Virginia			<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		
<b>13. FATHER'S NAME</b> Henry Sowards, Sr.			<b>14. MOTHER'S MAIDEN NAME</b> Pearl Harrison		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No			<b>16. SOCIAL SECURITY NO.</b> 407-12-1001		
<b>17. INFORMANT</b> BCH-Records			<b>ADDRESS</b> 4940 Eastern Avenue Baltimore, Maryland 21224		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I. <b>189.0 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Metastatic Tumor to Lungs, Bones etc.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Renal Cell Carcinoma.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b> <b>Congestive Heart Failure, mild.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b> <b>5 months</b> <b>5 months</b> <b>1 month.</b>		
<b>19A. DATE OF OPERATION</b> 2		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> _____		<b>20A. AUTOPSY?</b> (Yes or No) Yes	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) _____	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) _____		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> _____	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> 11/16 19 91 <b>to</b> 1/13/ 19 91 <b>that (I) (we) last saw the deceased alive on</b> 1/13/72 <b>and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> William P. Hunt M.D.			<b>23B. DATE SIGNED</b> Jan 17, 1972		
<b>23C. PHYSICIAN'S NAME (Type)</b> William P Hunt M.D.			<b>23D. ADDRESS</b> Baltimore City Hospitals 4940 Eastern Avenue 21224		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 1/17/72		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Bel Air Memorial Gardens	
<b>24D. LOCATION</b> (City, town, or county) (State) Bel Air, Maryland		<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 17 1972			
<b>25B. NAME OF REGISTRAR</b> Robert E. Fisher, Jr.		<b>25C. FUNERAL DIRECTOR</b> John J. Duda, 7922 Wise Ave. Dundalk, Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00480</b>	
L-251 72 00480		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Marie C. LeCompte</b>		2. DATE AND HOUR OF DEATH <b>JAN. 13, 1972 2:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2529 W. WOODWELL RD. # 22</b>	
5. SEX <b>Female</b>	6. RACE <b>Can.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/14/96</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>75</b>
11. BIRTHPLACE (State or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benoit</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-09-7518</b>	
17. INFORMANT <b>2523 W. Woodwell Road Mrs. Mazie Sizemore, Dundalk, Md. 21222</b>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>LEFT VENTRICULAR FAILURE</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <b>DEC. 28 1971</b> to <b>JAN. 13 1972</b> that (if we) last saw the deceased alive on <b>JAN. 13 1972</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (if we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Armando C. DiJanco, M.D.</b>		23B. DATE SIGNED <b>Jan 13, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARMANDO C. DIJANCO, M.D.</b>		23D. ADDRESS <b>Sinai Hospital Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>John A. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	

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ATOMIC TIME

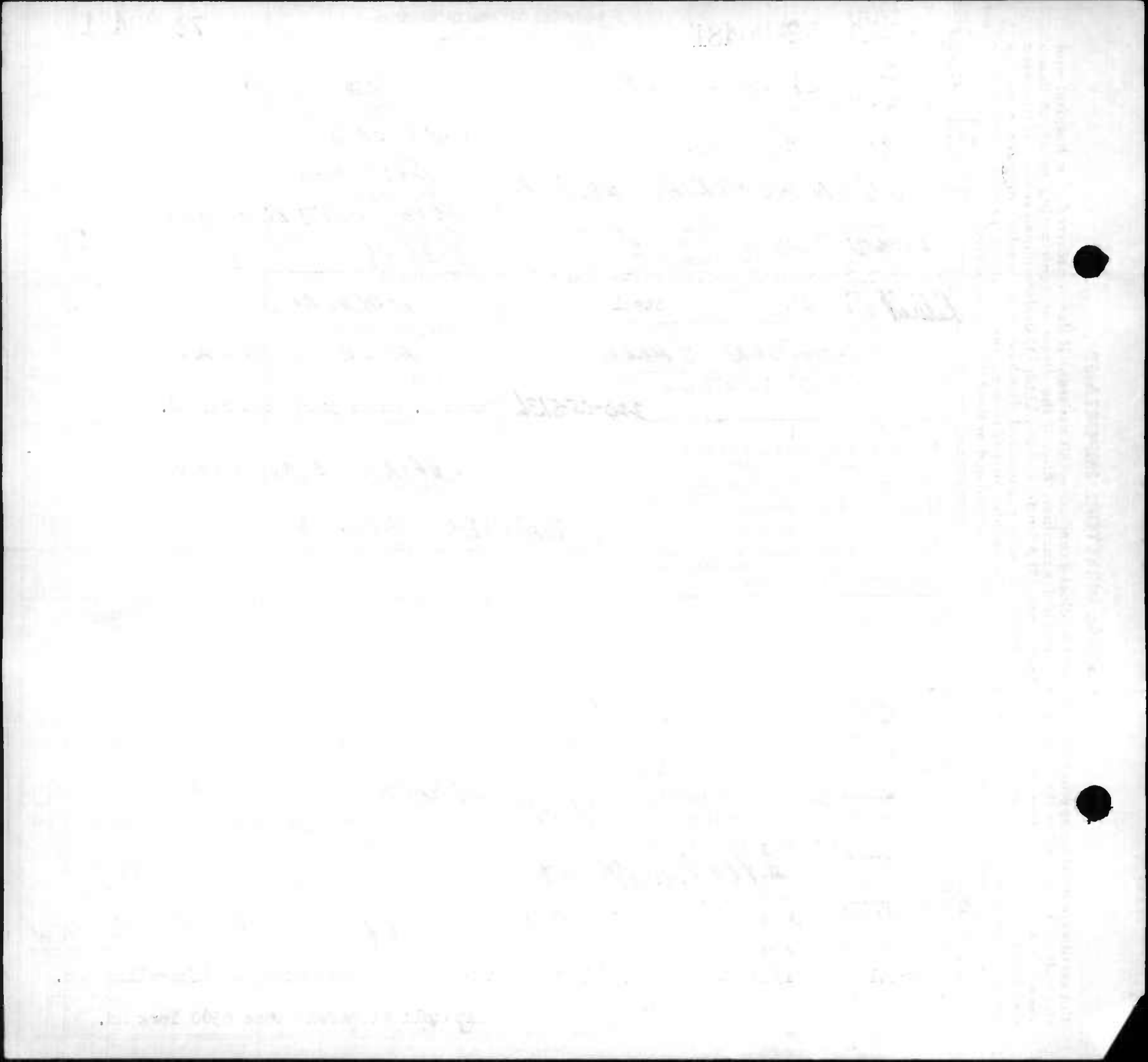
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00481</b>	
<b>R-520 72 00481</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>ALICE RUNGE</b>		2. DATE AND HOUR OF DEATH <b>1-11/72 5:45 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>903</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3606 MONTEREY ROAD APT. F</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	9. AGE (In years last birthday) <b>53</b> If Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMPSON O'HARA</b>		14. MOTHER'S MAIDEN NAME <b>ALICE F. MCNOLLY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-05-8136</b>	
17. INFORMANT <b>James T. Runge 3606 Monterey Rd.</b>		ADDRESS	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC RENAL FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>DIABETES MELLITUS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/30/71</b> 19 to <b>1/11/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/10/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. J. BUSTO. M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/14/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Reistertown Rd Pikesville Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>	
25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>		ADDRESS <b>Home 6500 York Rd.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-400		BALTIMORE CITY HEALTH DEPARTMENT		72 00482	
72 00482		CERTIFICATE OF DEATH		REG. NO. 72 00482	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LILLY, Betty Jo		1/12/72 10:25 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		2644	
The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5902 Frankfort Avenue			
5. SEX Female	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/30	9. AGE (In years last birthday) 41	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Ernest L. Lilly		14. MOTHER'S MAIDEN NAME Della Buckland		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u> (B) <u>metastatic Ca. malignant effusion</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>massive Ca. of breast</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>1 yr</u> <u>18 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 12/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of breast		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/7 19 72 to 1/12 19 72 that (I) (we) last saw the deceased alive on 1/12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JF Hobbs		23B. DATE SIGNED 1/12/72			
23C. PHYSICIAN'S NAME (Type) Jean F. Hobbs, MD.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 1/15/72		24C. NAME of CEMETERY or CREMATORY Sunset Mausoleum	
24D. LOCATION Beckley, West Virginia		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR C. F. Baker, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld	
				ADDRESS 6500 York Rd	

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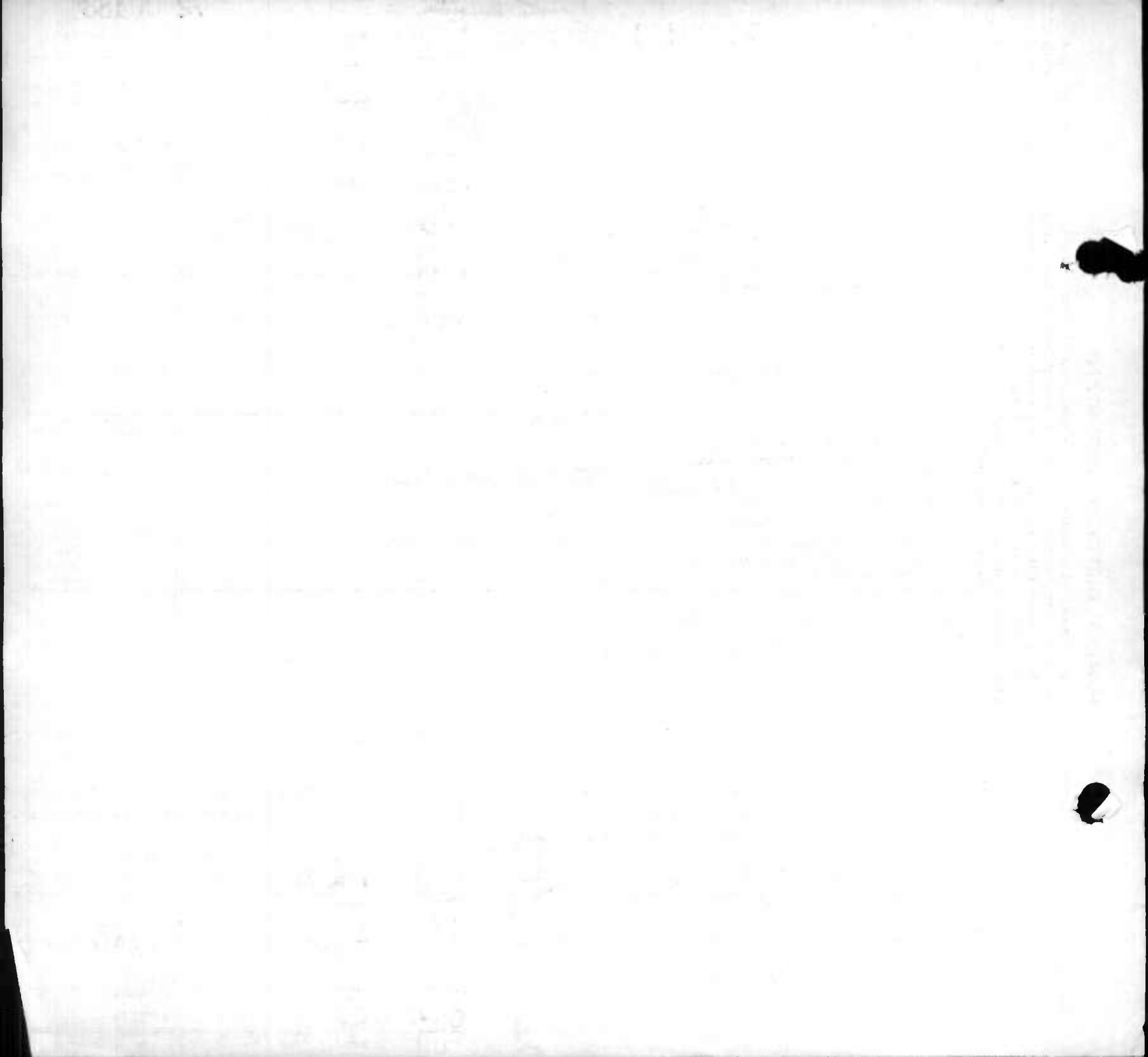
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00483</u>
BIRTH NO. <u>B-150</u>		72 00483		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>MARY BUFFIN</u>		2. DATE AND HOUR OF DEATH <u>1. 14. 72</u> <u>4:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>302</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME &amp; HOSPITAL.</u> <u>BALTIMORE</u>		C. CITY OR TOWN <u>CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>924 E. BALTIMORE ST.</u> <u>21202</u>		
5. SEX <u>F.</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12. 11. 34.</u>	9. AGE (In years last birthday) <u>36</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>		13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>911-19-0945</u>		
16. SOCIAL SECURITY NO. <u>911-19-0945</u>		17. INFORMANT <u>Hospital Chart.</u>		
18. <u>571.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cirrhosis of Liver</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Alcoholism.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>long standing.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>01. 01. 1972</u> to <u>1. 14. 1972</u> , that (I) (we) last saw the deceased alive on <u>01. 14. 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Satpal Singh</u>		23B. DATE SIGNED <u>1. 14. 72</u>		
23C. PHYSICIAN'S NAME (Type) <u>SATPAL SINGH MD</u>		23D. ADDRESS <u>CHURCH HOME &amp; HOSPITAL.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-17-72</u>		24B. DATE <u>1-17-72</u>		
24C. NAME OF CEMETERY or CREMATION		24D. NAME OF CEMETERY or CREMATION		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>		25B. NAME OF REGISTRAR <u>Subal E. Gabyo</u>		
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCED				



<p style="font-size: 24pt; margin: 0;">M-220</p> <p style="font-size: 24pt; margin: 0;">72 00484</p> <p style="font-size: 24pt; margin: 0;">72 00484</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> <p>REG. NO. _____</p>	
BIRTH NO. _____			
1. NAME OF DECEASED (Type or Print) <b>Thelma Meseke</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 13 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 So. Balto. General</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 13 72 7:10 p</b> M.	
6. SEX <b>female</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2544</b>	
7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Dec 13, 1912</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10. AGE (In years last birthday) <b>59</b>	11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b>	E. STREET AND NUMBER <b>612 Washbourne Avenue</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Luther H. Sanders</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>	
15. MOTHER'S MAIDEN NAME <b>Margaret Meyers</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>219 22 0479</b>		18. INFORMANT ADDRESS <b>Irvin L Meseke 612 Washbourn Ave 21225</b>	
19. <b>E 953X</b> CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Hanging	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Basement - 612 Washbourne Ave.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>1 13 72 un</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject hanged herself.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>1/14/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy Balto 21225</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>McCully Funeral Home</b>		ADDRESS <b>237 Patapsco Ave</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>DOMINIC MUSCALLI</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>January 12, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12, 1972</b> 4:55 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>7 SEPT 1914</b>	10. AGE (In years last birthday) <b>58</b>	E. STREET AND NUMBER <b>2337 Searles Road</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OPERATOR</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>SHIPBUILDING</b>	
15. MOTHER'S MAIDEN NAME <b>MABELINE D. SEVERSTR</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>213-073852</b>		18. INFORMANT ADDRESS <b>ELIZABETH MUSCALLI, 2337 SEARLES RD, BALTO, MD 21222</b>	
19. <b>412.4</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> January 13, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>15 JAN 72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>JACOB HEART CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO CO, MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>	25B. NAME OF REGISTRAR <b>Robert L. [unclear]</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Cherry Funeral Home, Dundalk, Md.</b>	

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RECEIVED AND FORWARDED TO THE

UNITED STATES DEPARTMENT OF THE ARMY

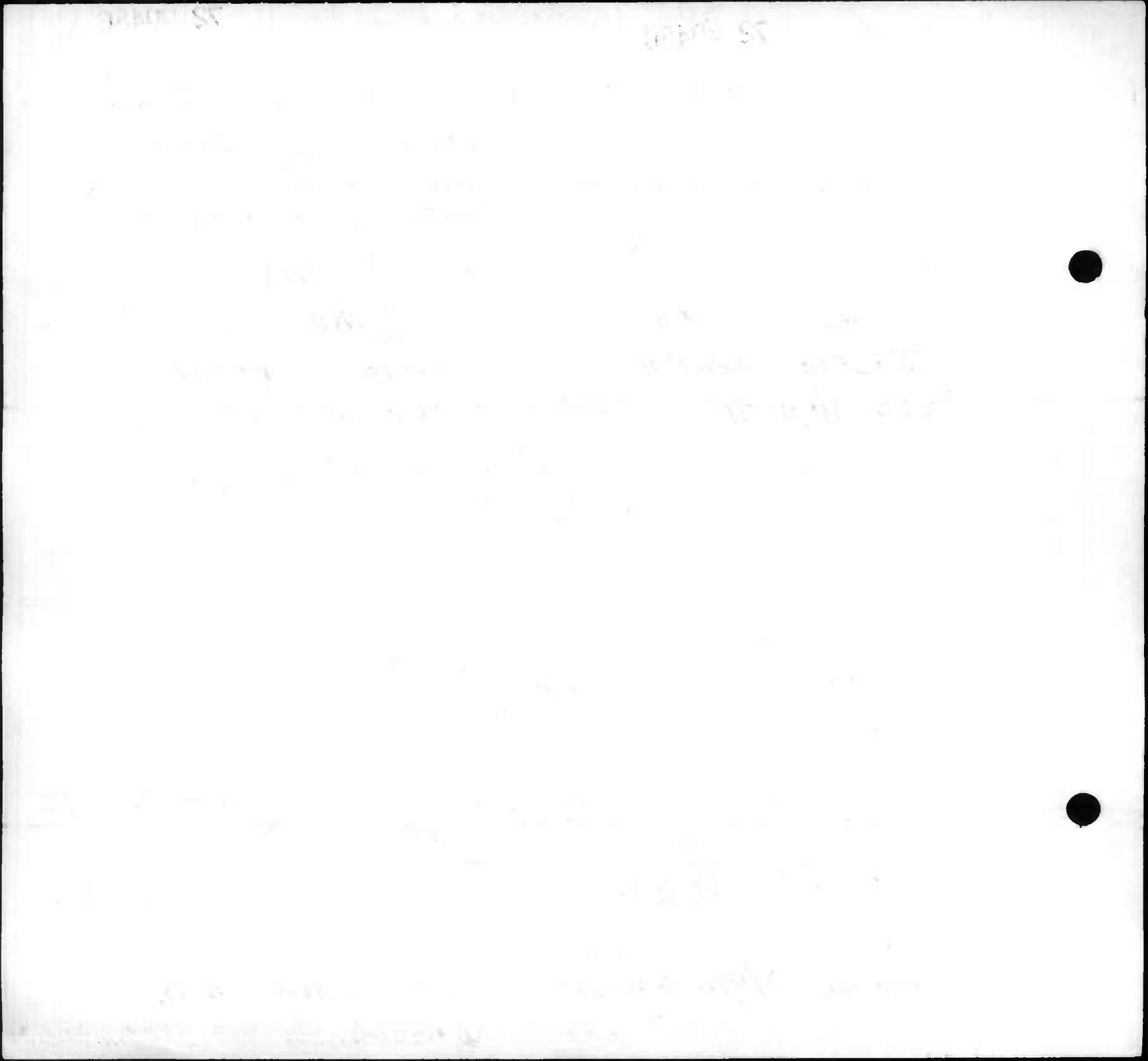
OFFICE OF THE ADJUTANT GENERAL



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-130		72 00486		BALTIMORE CITY HEALTH DEPARTMENT		72 00486	
BIRTH NO.		72 00486		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>CHARLES F. SPATH</b>				2. DATE AND HOUR OF DEATH <b>1/12/72 10:30 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>ESSEX</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>48</b>				E. STREET AND NUMBER <b>215 BALLARD AVE.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01-31-10</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OK -</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH SPATH</b>				14. MOTHER'S MAIDEN NAME <b>LILLIE - BETKEY</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>216-05-4070</b>		17. INFORMANT <b>Medical Record</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of (R) Lung c</b> ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>metastasis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Lung</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT/WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-2-72</b> to <b>1-12-72</b> that (I) <del>was</del> last saw the deceased alive on <b>1-12-72</b> and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. C. Ugorji M.D.</b>				23B. DATE SIGNED <b>1-12-72</b>		23C. PHYSICIAN'S NAME (Type) <b>C. C. UGORJI M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>John J. ...</b>		25C. FUNERAL DIRECTOR <b>John J. ...</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

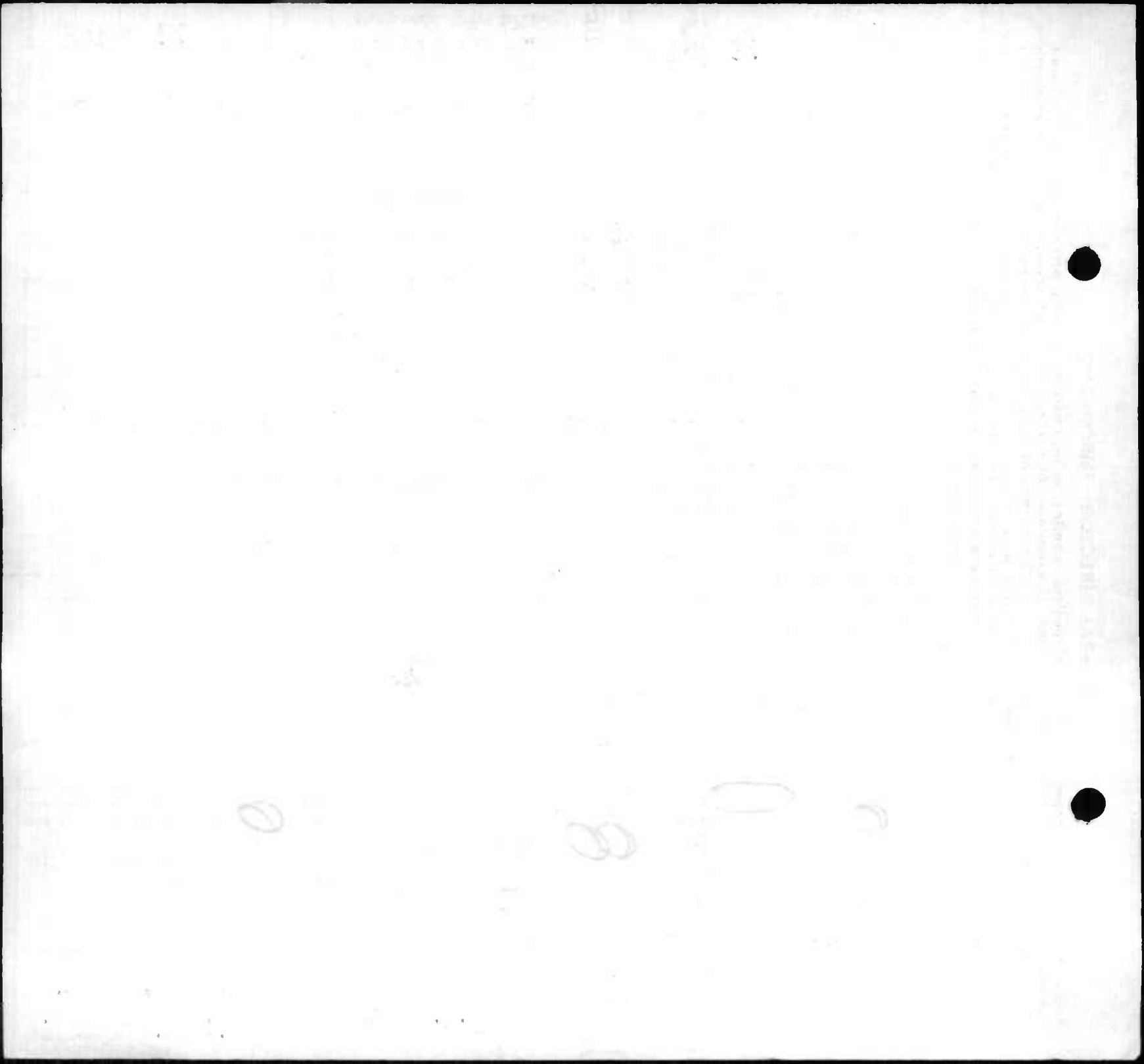
BIRTH NO. <b>S-432</b>		72 00487		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <b>72 00487</b>	
1. NAME OF DECEASED (Type or Print) <b>SCHULTZ, MRS. IRENE T.</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 10, 1972 11:20 A.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>The Gundry Sanitarium, Inc.</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Gundry Sanitarium, Inc. To St Agnes Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> E. STREET AND NUMBER <b>2023 Cedar Circle Drive</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/7/1879</b>	9. AGE (In years last birthday) <b>92</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George S. Throop</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Fuhrer</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-7316</b>		17. INFORMANT <b>Dr. Kathryn Schultz-daughter</b> <b>2023 Cedar Circle Drive, Baltimore</b>			
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Failure</b> <b>Arteriosclerotic Heart Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>4 weeks</b> <b>15 years</b> <b>15 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Brain Syndrome</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 7</b> 19 <b>67</b> to <b>January 10</b> 19 <b>72</b> that (I) <del>we</del> last saw the deceased alive on <b>January 10</b> , 19 <b>72</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Alfred J. Shulman, M.D.</b>				23B. DATE SIGNED <b>1/10/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Alfred J. Shulman, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>1/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Crematorium</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Edgar E. ...</b>		25C. FUNERAL DIRECTOR <b>H. Sander &amp; Sons, Inc., Balto., Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

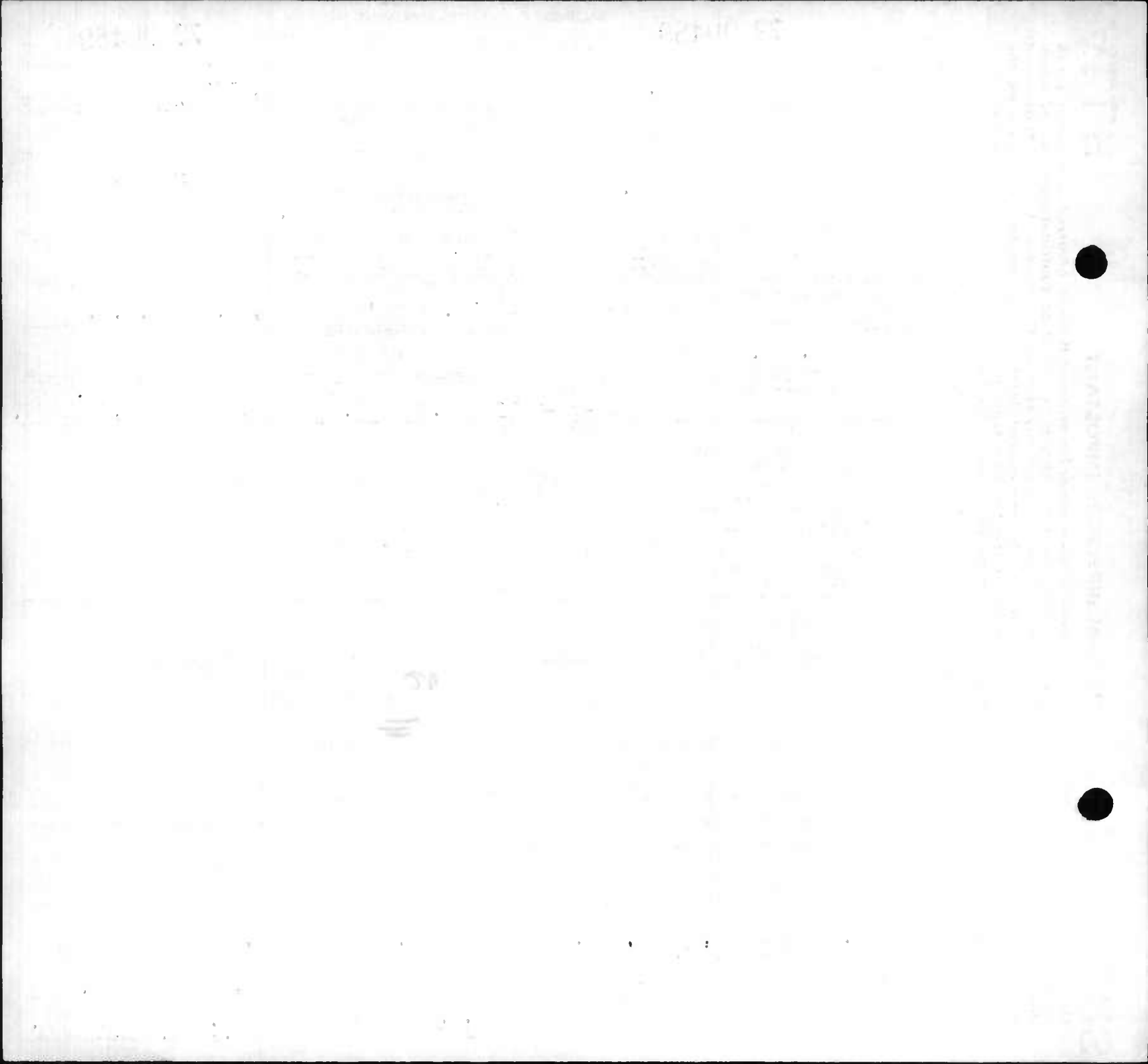
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 00488</span>	
S-500		72 00488		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SWEENEY JAMES BLAINE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JANUARY 14 1972 6:35 P. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">44 UNION MEMORIAL HOSPITAL</span> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">1201</span>			
5. SEX <span style="font-size: 1.2em;">M</span>		6. RACE <span style="font-size: 1.2em;">W</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">V.P. MERCHANT MARINERS</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">STEAMSHIP</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">09-12-83</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">88</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">SAMUEL SWEENEY</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY MACABEE</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-07-5418</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MRS. ELIZABETH P. SWEENEY (SAME)</span>			
18. <span style="font-size: 1.2em;">142.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">RESPIRATORY ARREST</span> (B) <span style="font-size: 1.2em;">CEREBRAL METASTASIS</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">CAROTID TUMOR</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">01/12</span> 19 <span style="font-size: 1.2em;">12</span> to <span style="font-size: 1.2em;">01/14</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">01/14</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/14/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JESSE V. VILLARON</span>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1/17/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Woodlawn</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 17 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">H.W. Jenkins &amp; Sons Co.</span>	
				ADDRESS <span style="font-size: 1.2em;">4905 York Rd. Balto., Md. 21212</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-325		72 00489		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00489	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Mae S. Dodson			
2. DATE AND HOUR OF DEATH January 15, 1972 1 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 00				IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 617 Harwood Ave.			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland		B. COUNTY 2778		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 617 Harwood Ave.				5. SEX F			
6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/30/1898		9. AGE (in years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Commercial Credit		11. BIRTHPLACE (State or foreign country) St. Mary's County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas G. St. Clair				14. MOTHER'S MAIDEN NAME Ida Burroughs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-22-2613		17. INFORMANT Mrs. Jane D. Horning, Bethesda, 20014 Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C. Dis. (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? No		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 15 to Jan 15 1972 that (I) (we) last saw the deceased alive on Jan 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles E. Carr, Jr.				23B. DATE SIGNED 1/15/72		23C. PHYSICIAN'S NAME (Type) Dr. Charles E. Carr, Jr.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR H.W. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>B-400</b> BIRTH NO.		<b>72 00490</b> BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 00490</b>	
1. NAME OF DECEASED (Type or Print) <b>Louise M. Boyle</b>			2. DATE AND HOUR OF DEATH <b>1/15/1972</b> <span style="float: right;"><b>1:50 P</b></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Edgewood Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1201</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Broadview Apartments</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-30-1889</b>	9. AGE (in years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Charles</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			14. MOTHER'S MAIDEN NAME <b>2</b>		16. SOCIAL SECURITY NO. <b>215-10-6214</b>
17. INFORMANT <b>Mr. Robert B. Boyle</b>			ADDRESS <b>319 Tuscany Rd. 21210</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-Vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis -</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC BRONCHITIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CHRONIC BRONCHITIS</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/14</b> 19 <b>72</b> to <b>1/15</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/14</b> 19 <b>72</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anthony F. Carozza M.D.</b>			23B. DATE SIGNED <b>1-15-72</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> DEGREE
23C. PHYSICIAN'S NAME (Type) <b>Anthony F. CAROZZA</b>			23D. ADDRESS <b>5212 York Rd Bn to Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>John E. Jones</b>		25C. FUNERAL DIRECTOR <b>Howe Jenkins Sons Co. 4905 York Rd Baltimore, Maryland 21212</b>	

1. The first part of the report is a summary of the work done during the period from 1 January to 31 March 1968.

2. The second part of the report is a detailed account of the work done during the period from 1 April to 31 May 1968.

3. The third part of the report is a summary of the work done during the period from 1 June to 31 August 1968.

4. The fourth part of the report is a summary of the work done during the period from 1 September to 31 October 1968.

5. The fifth part of the report is a summary of the work done during the period from 1 November to 31 December 1968.



D-340

72 00491

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 00491

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) Dudley, Howard E.

2. DATE AND HOUR OF DEATH

January 14, 1972

1:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

Virginia

C. CITY OR TOWN

Richmond

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

311 W Franklin Street

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7/21/00

9. AGE (In years last birthday)

71

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Executive

10B. KIND OF BUSINESS OR INDUSTRY

Tobacco

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Oliver

Dudley

14. MOTHER'S MAIDEN NAME

Lucy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WW I &amp; WW II

16. SOCIAL SECURITY NO.

223-03-3235

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: Records Baltimore, Maryland 21224

18. 204.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Severe Metabolic Acidosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8 hours

(B) Bilateral Lower Lobe Pneumonia

DUE TO, OR AS A CONSEQUENCE OF:

1 week

(C) Acute Blastoid Leukemia

DUE TO, OR AS A CONSEQUENCE OF:

2 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from January 8, 1972 to January 14, 1972 that (T) (we) last saw the deceased alive on January 14, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William P. Hunt M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

January 14, 1972

23C. PHYSICIAN'S NAME (Type)

William P. Hunt M.D.

DEGREE

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

1/17/72

24C. NAME OF CEMETERY or CREMATORY

Greenmount

24D. LOCATION

Baltimore,

(City, town, or county)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1972

25B. NAME OF REGISTRAR

Robert E. Hunt, Jr.

25C. FUNERAL DIRECTOR

HOW Atterkins

Sons Co. 1405 York Rd. Balto., Md. 21212

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

LEARN ST

1040 55

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 00492</span>	
H-616		72 00492		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Edwin Laurence Harper		Jan. 13, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 708 Highwood Dr.				A. STATE Md.	
				B. COUNTY 2768	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 708 Highwood Drive 21212	
5. SEX MALE	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-27-1883	9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Artist		11. BIRTHPLACE (State or foreign country) Alexandria, Va.	
13. FATHER'S NAME Andrew J. Harper				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 064-03-9690	
17. INFORMANT Mr. Charles H. Harper, Jr.				ADDRESS 4003 Boxhill Lane 21210	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bilateral Bronchopneumonia</i> 2 days	
				(B) <i>Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF: 2 yrs	
				(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>ASCVD B.P.H.</i>				3 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>5/10/56</i> 19 to <i>1/13/72</i> 19 that (2) (we) last saw the deceased alive on <i>1/13/72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francis W. Gluck M.D.</i>				23B. DATE SIGNED <i>1/14/72</i>	
23C. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck				23D. ADDRESS 100 W. University Pkwy.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR <i>Robert C. Taylor, M.D.</i>		24F. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972					

14-2

12/12/14

12/12/14

12/12/14

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12/12/14

12/12/14

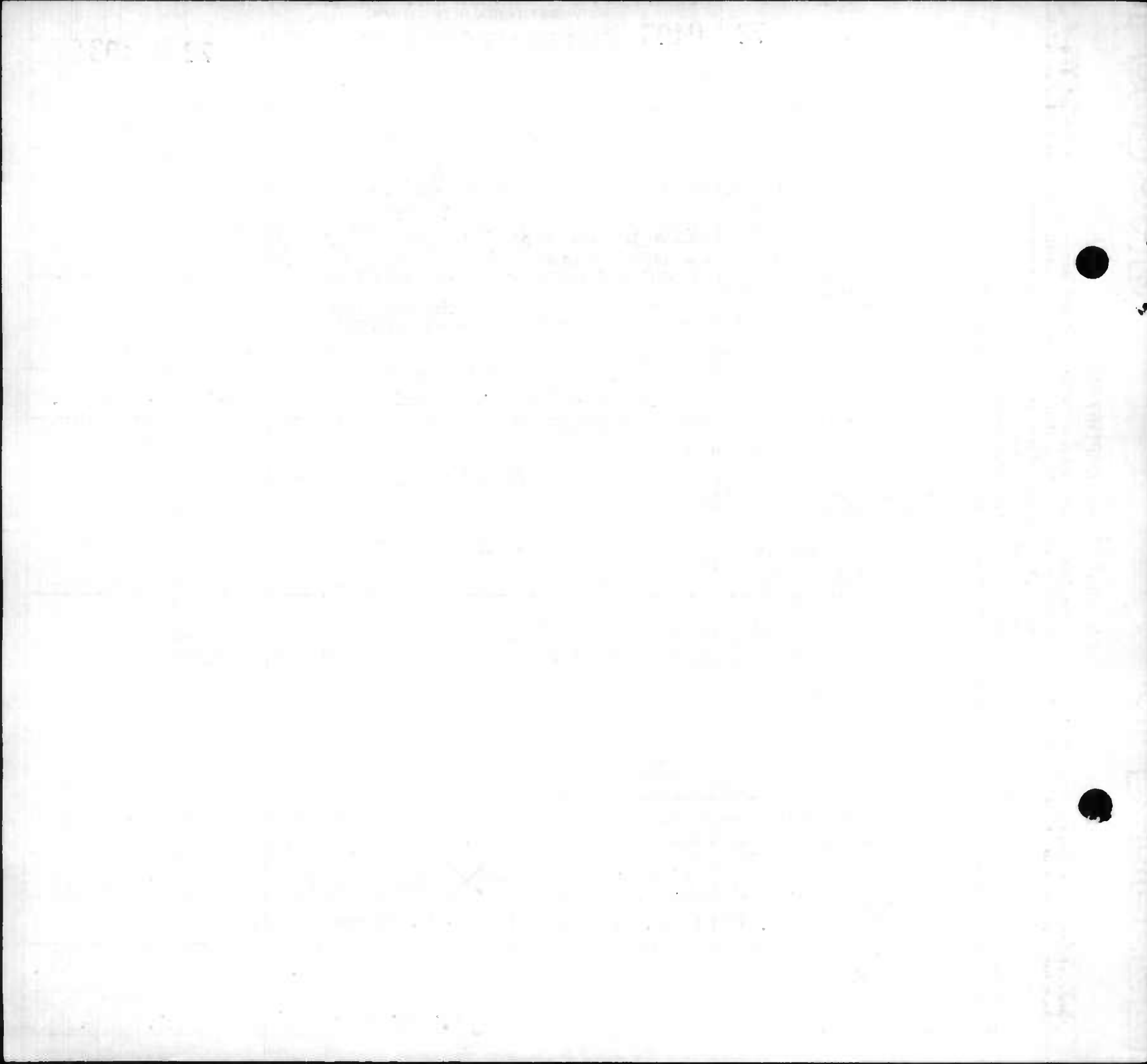
12/12/14

12/12/14

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
72 00493					REG. NO. 72 00493										
BIRTH NO. <u>P-400</u>					1. NAME OF DECEASED (Type or Print) <u>John Gilman D'Arcy Paul</u>					2. DATE AND HOUR OF DEATH <u>Jan. 12, 1972</u> <u>18 p.m.</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2711</u>										
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>4307 Underwood Road</u>					C. CITY OR TOWN <u>Baltimore</u>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
					E. STREET AND NUMBER <u>4307 Underwood Road</u> <u>21218</u>										
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-31-1887</u>		9. AGE (In years last birthday) <u>84</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>					
										12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>D'Arcy Paul</u>					14. MOTHER'S MAIDEN NAME <u>Charlotte Abbott Gilman</u>										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>220-44-7051</u>					17. INFORMANT ADDRESS <u>Mercantile-Safe &amp; Deposit &amp; Trust Co.</u>					
18. <u>4855</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>b. on ch. pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>3 days</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).															
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>No</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>19 68</u> to <u>present</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7 p.m. 1-12</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
23A. SIGNATURE <u>Philip F. Wagley</u>										23B. DATE SIGNED <u>1-13-72</u>					
23C. PHYSICIAN'S NAME (Type) <u>Dr. Philip F. Wagley</u>										23D. ADDRESS <u>9 E. Chase Street</u>					
24A. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>				24B. DATE <u>1-17-72</u>				24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>				25B. NAME OF REGISTRAR <u>Philip F. Wagley</u>				25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>				ADDRESS <u>4905 York Road Balto., Md. 21212</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00494

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Walter Johnson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>15</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2424 W. Lafayette Ave.</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>15</b> Year <b>72</b> Hour <b>10:55 a.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1605</b>	
9. DATE OF BIRTH <b>3-1-95</b>		10. AGE (In years lost birthday) <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grant Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Lusie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-2010</b>	
17. INFORMANT <b>Cora L. Johnson</b>		18. ADDRESS <b>2424 W. Lafayette Ave.</b>	
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Peter Lipkovic</b> M.D. EXAMINER'S NAME (Type): <b>Peter Lipkovic, M.D.</b> DATE SIGNED: <b>1/16/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Int. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>a. a. County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Milton E. Ellickson</b>		25D. ADDRESS <b>1129 N. Caroline St.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-654		72 00495		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00495	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) John Arnold			
2. DATE AND HOUR OF DEATH 1/16/72 9 AM				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 1 Baltimore City Hosp. 4940 Eastern Avenue, Baltimore, Md.				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland Baltimore C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rte 1 Box 329A				5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8/5/1904 9. AGE (In years last birthday) 67				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Steel Worker			
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Val Arnold				14. MOTHER'S MAIDEN NAME Annette Cross (Annette)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) (unk) No				16. SOCIAL SECURITY NO. 213-07-1205			
17. INFORMANT Records: BCH-4940 Eastern Ave. 21224 Wife - Judie Arnold (Same)				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(A) IMMEDIATE CAUSE Possible Acute M.I. Low min. DUE TO, OR AS A CONSEQUENCE OF: (B) Saline depletion 2° gastroenteritis 3 days DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD & Aortic insufficiency 6 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ② CVA & residual Rheumatism 1966				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1/15 1972 to 1/16 1972 that (I) (we) last saw the deceased alive on 1/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE P. Kurzweil				23B. DATE SIGNED 1/16/72		23C. PHYSICIAN'S NAME (Type) P. Kurzweil M.D.	
23D. ADDRESS Baltimore, Maryland 21224 4940 Eastern Ave Baltimore Hosp.				24A. BURIAL CREMATION REMOVAL (Specify) Burial			
24B. DATE 1-20-72				24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park			
24D. LOCATION Arbutus, Md.				25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972			
25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
25D. ADDRESS				25E. ADDRESS			

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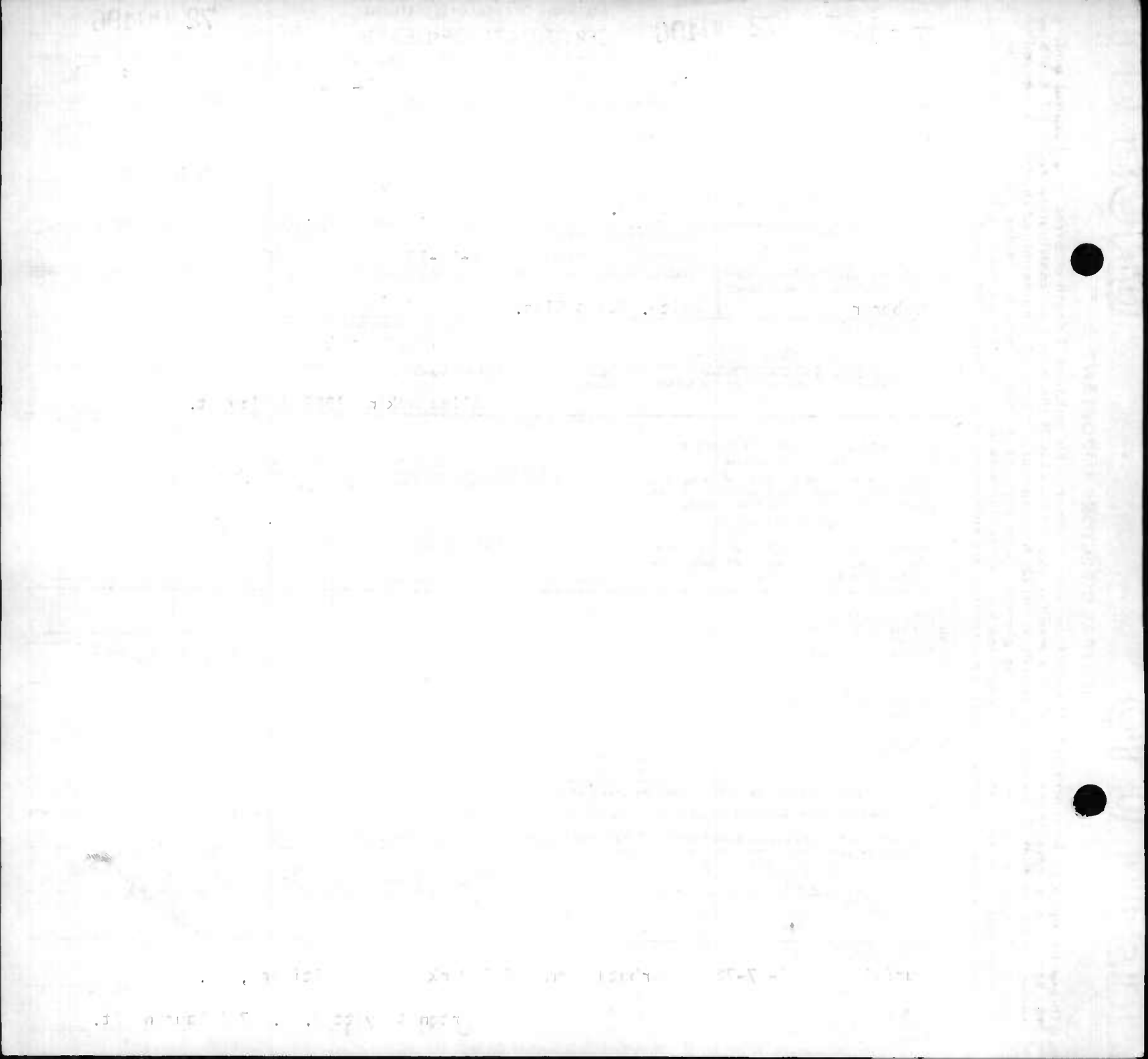
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 00496</b>	
A-325 72 00496					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Adkins, Robert</b>		2. DATE AND HOUR OF DEATH <b>1-13-72</b> <b>8:05 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>909</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37</b> <b>Mercy Hospital, Inc.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Elec.</b>		8. DATE OF BIRTH <b>8-28-30</b>	
13. FATHER'S NAME <b>Robert Williams</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Adkins</b>		9. AGE (In years last birthday) <b>41</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Informant Address <b>Alice Adkins 1325 Valley St.</b>					
18. <b>303.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Upper GI Bleeding</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Severe Hepatic Failure</b> <b>Chronic Alcoholism</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>12/29</b> 19 <b>71</b> to <b>1/13</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>1/23/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>T. P. Detrich, M.D.</b>		23B. DATE SIGNED <b>1/14/72</b>		23C. PHYSICIAN'S NAME (Type) <b>T. P. DETRICH, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1972</b>		25B. NAME OF REGISTRAR <b>Charles E. Jones</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>	
				25D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25E. ADDRESS <b>1701 Laurens St.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-653		72 00497		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00497	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ben Grant</u>				2. DATE AND HOUR OF DEATH <u>1-15-72</u> <u>4:30</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1504</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Key Circle Hospice</u> <u>1214 Eutaw Pl.</u> <u>Bethesda, Md 21217</u>						C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1670 W. North Ave.</u>									
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/18/1904</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mark Grant</u>				14. MOTHER'S MAIDEN NAME <u>Emily Patterson</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>249-07-6950</u>		17. INFORMANT <u>Covine Grant</u>		ADDRESS <u>1670 W. North Ave.</u>	
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF, <u>Arteriosclerosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Unknown</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CVA - R middle cerebral artery</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>13 Oct 1970</u> to <u>15 Jan 1972</u> that (I) (we) last saw the deceased alive on <u>27 Dec 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Sam H. H. H.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>15 Jan 72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-17-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Estelle S.C. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Estelle, South Carolina</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. H. H.</u>		25C. FUNERAL DIRECTOR <u>Moore</u>		ADDRESS <u>Dyett F.H. 1701-1700</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00498		72 00498	
BIRTH NO. <span style="font-size: 1.5em;">J-525</span>		72 00498		72 00498	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LENA JOHNSON</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1-15-72</span> <span style="font-size: 1.2em;">9:30 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">48 MARYLAND GENERAL HOSPITAL</span> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">BALT.</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALT.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">1069 ARGYLE AVE.</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">N N</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">04-09-04</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">67</span>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Charlotteville, VA.</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Silas Mack</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Amanda Mack</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-38-4141</span>			17. INFORMANT <span style="font-size: 1.2em;">HUSBAND James Johnson</span> ADDRESS <span style="font-size: 1.2em;">Same</span>		
18. <span style="font-size: 1.2em;">41231</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <span style="font-size: 1.2em;">PULMONARY EDEMA</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">ARTERIOSCLEROTIC HEART DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month: Day: Year: Hour: )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1-9-72</span> 19 to <span style="font-size: 1.2em;">1-15</span> 1972 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1-15</span> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Michael Grassano M.D.</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">1-15-72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MICHAEL GRASSANO M.D.</span>
23D. ADDRESS <span style="font-size: 1.2em;">Maryland General Hosp</span>			23E. DATE <span style="font-size: 1.2em;">1-17-72</span>		
23F. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Garden of Eternity</span>			23G. LOCATION <span style="font-size: 1.2em;">Finksburg, Md.</span>		
23H. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 17 1972</span>			23I. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Johnson</span>		
23J. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Ruth Jones</span>			23K. ADDRESS <span style="font-size: 1.2em;">1701-1701</span>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-615		72 00499		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00499	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ella Griffin				2. DATE AND HOUR OF DEATH 11/13/72 1 3 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2600 Liberty Heights Ave. Provident Hospital Complex Baltimore, Maryland 21215 39				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1602 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 912 N. Carey St.			
5. SEX Female	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-21-1908	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Florence Sample				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mr. Oliver Griffin-Husband			
18. ADDRESS Same				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) R/O CA OF PANCREAS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from JAN 8 1972 to JAN 13 1972 that (I) (we) last saw the deceased alive on JAN 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Rayman I. Ally MD 23B. DATE SIGNED 11/13/72	
23C. PHYSICIAN'S NAME (Type) RAYMAN I. ALLY MD		23D. ADDRESS PROVIDENT HOSP INC.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Robert E. Johnson		25D. ADDRESS 1701 - Waverly St.		VS 150-REV. 1/1/68			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-000 72-00500		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00500	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		x Towe Jule (Julius)		1/14/1972 7:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		A. STATE Maryland		B. COUNTY 1601	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 907 Edmondson Ave.					
5. SEX M	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-00	9. AGE (in years last birthday) 71	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Nat Towe		14. MOTHER'S MAIDEN NAME Othelia Towe	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212072189		17. INFORMANT GRACE Towe - 3065-Walbrook Ave	
18. 3/19/31 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, etc., if it appears to be the result of injury or complication which caused death.)		Chronic obstructive pulmonary disease		years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, existing prior to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fractured Ribs			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Renal failure		3 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Renal failure			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11/8/71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell down stairs	
22. I certify that (1) (this hospital) attended the deceased from Nov 22 1971 to Jan 14 1972 that (1) (we) lost the deceased alive on Jan 14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rayman I. Alley M.D.		23B. DATE SIGNED 1/14/72			
23C. PHYSICIAN'S NAME (Type) RAYMAN I. ALLEY		23D. ADDRESS PROVIDENT HOSP INC BALT MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balt Co, Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR James E. [unclear]	
25C. FUNERAL DIRECTOR Raphael James Morton		25D. ADDRESS 1701 St [unclear]			

